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ON ALOPECIA AREATA AND ITS RELATION TO RINGWORM.

I do not think that any one will read attentively the items of evidence which I am about to produce as to the clinical history of Alopecia, without coming to much the same conclusions that I have arrived at myself. The chief of these conclusions is, that all well-characterised cases of alopecia areata are in direct connection either with ringworm or pityriasis versicolor, and that they have little or nothing to do with the state of the patient's general health. Under the head of well-characterised cases I count all in which the eruption begins as smooth, bald patches which are abruptly margined, which tend to spread at their edges, and are attended by the development of others in their vicinity. Great latitude is to be allowed in reference to the extent to which the falling of the hair progresses. In some cases the patient may lose every hair on the body in the course of a few months, whilst in others the patch may remain single and solitary for a year or more. Differences in the rate or extent of progress do not seem to me to imply any difference in the essential nature of the disease; and I much doubt whether there is any class of cases, in which the shedding of the hair becomes universal, which are not of the nature of alopecia areata.

The condition which is chiefly likely to give difficulties in the diagnosis of alopecia areata is its simulation in syphilis. For the most part, when syphilitic patients lose their hair,

they lose it diffusedly, as is the case in senility and after fevers. There is, however, another condition met with in the secondary stage of syphilis which very closely resembles the areate form of alopecia. In this the hair falls in patches. These cases may, however, I think, generally be distinguished by observing that the patches are not nearly so abruptly margined, and that they are not so glossy, nor the skin so thin, as in the non-syphilitic form. There is also usually a thinning of the hair on the rest of the scalp, a feature which is never present in true alopecia areata.

With these preliminary statements I will now proceed to the narration of my cases, reserving further comment for the end of my paper.

Case 1.—A man named S——, florid, and in excellent health, was under my care in January, 1881, for smooth bald patches of alopecia on the back of head and on his chin; they were advancing. He had five children, and one of them had, not long ago, suffered from ringworm; he believed that his wife had also contracted it from the child, but had soon got well.

Case 2.—A young man, aged 19, Mr. C——, was the subject of alopecia on the back of his head, in the ordinary form of large smooth patches. The history was that, when a boy at school, he had suffered for a long time from ringworm.

Case 3.—A lady named F—— was brought to me by Mr. F. Mackenzie on account of a tumour in one of her breasts. She had also, however, a large patch of characteristic alopecia, which had formed in the last six months. She was 36 years of age; she had never previously had any alopecia, but she was aware that she had suffered from ringworm in childhood. She stated that she had had several patches, but as far as she could remember none were on the precise site of that now occupied by the alopecia.

Case 4.—The connection between ringworm and alopecia areata is possibly illustrated by a patient who was brought to me by Dr. Bright, of Forest Hill. This patient, a lady of 45, was rapidly losing the hair from the back of her head by the ordinary form of alopecia areata. The disease had begun at the usual place, and the patches had been from the first as smooth and glossy as possible. Recently another bald patch had commenced near the vertex, and on it the skin also was thin, pale, and smooth. Not a single scale could have been obtained from any of the areas, nor was there a broken hair to be seen. The history was, however, that Miss G——'s maidservant had been under treatment for ordinary ringworm of the nape of the neck six weeks before her mistress became the subject of alopecia.

Case 5.—A youth named McI——, aged 18, was under my care in January, 1885, with typical patches of alopecia areata. His history was peculiar: he said that about the age of seven his hair began to fall in patches, and that from seven to nine he was almost bald. Then the hair grew again, but two years later he had a single patch of what his medical attendant said was ringworm. This was followed by baldness, but again, under the use of a lotion, he got a good head of hair, and kept it until about six months before I saw him. At the time of his visit to me he had several patches, quite round, and as large as crown-pieces.

Case 6.—Dr. G——, an Indian surgeon, aged 46, consulted me on account of patches of alopecia on his scalp. It was well-marked: the patches were round, but small. It affected one side of his moustache also, and had indeed begun there. He believed that he had never had ringworm, but three sources of cryptogamic contagion were possible. He had been attending children with ringworm and alopecia; he had himself formerly suffered in India from Dobie's itch, and he was the subject of pityriasis versicolor on his chest.

Case 7.—A butler, aged 35, was under my care in 1887 for alopecia patches in his beard. He told me that, when a boy, his brother suffered from ringworm, but he did not remember having himself had it.

Case 8.—I saw a Miss T——, aged 22, in October, 1884, on account of complete alopecia of the scalp and eyebrows. It was a relapse, for I had treated her five years previously with success, and she had kept her hair for several years. There was a history of ringworm at the age of thirteen.

Case 9.—A lady named C——, aged 26, consulted me on July 6, 1887, on account of a single patch of alopecia areata on the left side of her head. It had been present four months. I found on inquiry that I had myself treated her brother for ringworm twenty years before. The two were then children together, and she was exposed to the risk of contagion. Her brother had had his ringworm two years before I saw it. It was not known that his sister ever caught it. In this case under treatment, in the course of three or four months the hair grew quite well. A year later, however, I saw Miss C—— again, on account of new patches on other parts of the scalp.

Case 10.—A man named L——, aged 50, consulted me on account of alopecia patches on his chin and scalp, which had been present six months. He told me that at the time the patches first showed themselves he had a niece staying in his house, whom he was accustomed to take on his knee, and who suffered from ringworm.

Case 11.—Mr. T. A——, aged 59, who consulted me on account of an urticarious eczema, was the subject also of alopecia areata. He had suffered from the latter for seven years, and had been under much treatment with only partial and temporary results. He still had large bald patches on the scalp, and his eyebrows and whiskers were in part destroyed. He well remembered that at about the age of eight he had

been blistered repeatedly for ringworm. Thus the interval in his case between the two maladies would be more than forty years.

Case 12.—A young man who consulted me for alopecia entirely denied all history of ringworm. He went home, and on the following morning I had a note from an elder brother, from which the following is a quotation :—"I beg to inform you that at the age of four years, I, the eldest brother, suffered from a ringworm on the head, acquired we do not know how, and that by infection or contagion from me, our mother subsequently had one on the forehead. Our mother has occasionally of late suffered from erysipelas of the face."

Case 13.—A young man, aged 23, who was sent to me by Dr. Macrae, of Westbourne Terrace, presented a somewhat peculiar form of alopecia. He was almost entirely bald, but his scalp was rough, and on many parts coarse hairs were presenting themselves in tufts, two or three together. Some of the hairs were white; the scalp looked almost as if it were in the position of an extensive thin scar. There was little or no scurfiness, and the sides of his head were less severely affected than the top. The history given was that in childhood he had had a beautiful head of hair. I thought it most probable that he had suffered from ringworm which had been attended by a severe condition of kerion.

Case 14.—Mrs. L——, of Stafford, aged 25, presented herself with patches so large that they involved almost the whole of the scalp; her eyelashes and eyebrows were also falling. She was in very good health, and stated that the present attack had commenced when she was pregnant, two years ago. Two years before her marriage, however—that is almost five years ago—she had a single small patch on the occiput, but got it well under treatment. She knew that in their childhood her brothers had suffered from ringworm, but she believed that she herself had escaped.

Case 15.—Mrs. E——, aged 41, mother of a large family, presented herself in 1881 with a large alopecia patch on the right side of the vertex. She said that it had begun four months previously, and that she had never had it before, and that she had never had ringworm. On her second visit to me, she stated that she had made inquiries at home, and had ascertained that when a child she *did* suffer from a ringworm on one temple. I treated this case with chrysophanic acid, and it was soon cured. Mrs. E. remained quite well for seven years, but in May, 1888, she came to me again with a relapse. She then had a patch of alopecia on the opposite side of the head to the former one. It was now, she said, exactly where her original ringworm patch had been. She was in excellent health, and the mother of eleven children. On October 24th, 1888, the hair had begun to grow on the patch she came for in May, but another bald place had come.

Case 16.—My creed has occasionally received confirmation by the occurrence of two examples of alopecia after ringworm in the same family. On December 8, 1890, a Mrs. G—— brought me one of her

boys, a lad of eleven, with large smooth patches of alopecia; they had been present about four months. "Has he ever had ringworm?" I asked. "Yes, about five years ago." "Had any of his brothers or sisters ringworm at the same time?" "Yes, his next brother had it." "Has he got any bald patches?" "Yes, he is just beginning in patches like those on this boy."

Case 17.—A gentleman aged 18 came under observation when the subject of complete alopecia of his scalp. He was quite bald, wearing a wig. His eyebrows and eyelashes were falling, but he still kept his moustache. He told me that at the age of 12 he had been kept at home for a year on account of what was called ringworm. The microscope was used by an experienced surgeon, and the fungus was recognised. He had been well for only about a year when the alopecia set in, the hair beginning to fall and to leave smooth bald patches.

Case 18.—A clergyman named G——, aged 25, consulted me on account of very extensive alopecia of the scalp in June, 1886. He had worn a wig for seven years, and had perseveringly tried a great deal of treatment by iodine, &c. His scalp was not wholly bald, but he kept the small tufts that remained closely cut. He had formerly lost his eyelashes, eyebrows, and the axillary and pubic hair. On some of these parts it had to some extent grown again. He knew of no history of ringworm, but the alopecia had begun, just as usual, by a single patch on the scalp at the age of 15.

Case 19.—I had occasion to see, with Mr. George Mackenzie, in December, 1888, a gentleman who was suffering from abscesses in connection with an attack of erysipelas of his leg. I found that he was quite destitute of hair (on the head and whole body), and he told me that he had consulted me about it when the alopecia was beginning. He told me that he had subsequently been under the care of many specialists, but had got no benefit; the alopecia had rapidly spread, and had denuded him of every hair on his body, including the eyebrows and eyelashes. At the time that he first consulted me (as I found, on referring to my notes) he was thirty-nine years of age, and had the bald patches on his occiput and over his ears. I then saw him on only one occasion (April 6, 1882). When I saw him on the second occasion (in 1888) he had for long abandoned himself to his lot, and despaired of any cure. There were a few straggling hairs on his cheeks and chin, and a little tuft of scalp-hair in front and above the right ear. This latter tuft was in itself sufficient to indicate that the disease had been serpiginous and not diffuse, for it was abruptly margined with acute angles. There was not the slightest evidence as to any kind of causation in this instance; the patient was a married gentleman in high position in society, of temperate habits, and in excellent health. He assured me that the time his hair began to fall he was not suffering from headaches, debility, or any disturbance of his health which he could appreciate. It was not known that he had ever been exposed to the contagion of either ringworm or

alopecia. It will be seen that the commencement of the disease, as is so common, on the back of the head, was suggestive of contagion from the chair. It may be added as curiously suggestive, but perhaps of no importance, that it was thought that some of the hairs had grown afresh during his severe illness; he had been five weeks in bed.

For other cases in which there was a clear history of antecedent ringworm the reader is referred to Nos. 25, 26, 27, 28, 33, 34, 35.

Some Cases illustrating Success in Treatment.

Case 20.—Miss P——, aged 53, was under my care for a number of almost symmetrical patches of alopecia areata, which had been present for a year or more, and were advancing. Her hair was rapidly thinning over the entire scalp, and the margins of the patches were not so well limited as usual. She was the subject of attacks of flushing of the scalp and head, possibly in connection with her period of life. She suffered also from rheumatic gout. My notes do not record any previous ringworm. She used during four months a chrysophanic acid ointment (ten grains to the ounce) every other day. She also took a mixture which contained arsenic and nux vomica. At the end of the four months, hair had grown on all the patches. When I saw her one year later, she described her head of hair as being "as good as when I was a young woman." In the first instance it had grown white, whilst latterly it had become dark. The cure was perfect. Miss P.'s general health had also much benefited, though she still suffered from gout.

Case 21.—I attended a Miss B—— for alopecia. On May 9, 1884, four years after the treatment and cure, I accidentally heard she remained quite well.

Case 22.—Mr. B—— has been several years under my observation on account of neurasthenia, &c. He had a single large patch of alopecia on his occiput, which was as big as an outstretched hand. I persuaded him to persevere with chrysophanic acid for more than a year. The hair at length grew well, and as I have since seen him repeatedly, I can testify that he has remained for three years, at least, without any relapse.

Case 23.—Miss B——, of Salisbury, was under my care in 1883, for patches of ordinary alopecia. Her hair grew again well, under treatment by chrysophanic acid; and three years later I had the pleasure of learning that she had had no relapse.

Case 24.—Miss T——, a lady of 34, who, so far as she knew, had never been exposed to the contagion of ringworm, came under my care when perfectly bald from alopecia. She had not a single hair on her head, only here and there a little soft down. She said that the hair had been coming out for nearly two years, but her complete baldness had only

been for six months. She had been under the care of several specialists. She was tall and thin, and had never been strong, but was not specially out of health; her circulation was, however, very feeble, and she complained that her head was easily tired. Her eyebrows were falling on both sides, and the eyelashes on the right side. She thought that there had never been the slightest attempt at re-growth of hair on any part where it had fallen. I prescribed, as usual, chrysophanic ointment, and gave her a mixture containing tincture of steel in full doses. I did not see her again for six months. On January 4, 1881, she came to me with the hair fairly well grown over almost the whole scalp; in some parts, however, there was still little more than down. She had used the ointment continuously and freely. Her eyebrows were growing again, but were white. I must not omit to mention that her right eyelashes were growing again, although, of course, she had not been able to use the ointment on the edges of the lids beyond the very slightest application. I saw this lady again in August, 1881; her hair had then grown well over the whole scalp, with the exception that on a single central patch, the size of a crown-piece, the hairs were still thin and short. The hair was thick and strong; her eyebrows and eyelashes had been reproduced in perfection. She was in much better health, and was still taking her medicine under the impression that she could not do without it. She had for some time disused her ointment, considering her cure complete. One year after the last note, Miss T—— came to me again with a relapse of her alopecia. The patches were again becoming bald, just as they had done in the first instance. They were as yet small, but they affected different parts, and had even attacked one eyebrow. Miss T—— said that she had never left off her medicine, though she had, of course, for long disused her ointment. I am sorry that my notes do not enable me to carry this case any further; I believe, however, that under the systematic resumption of the ointment the patient again recovered her hair. As regards the growth of the hair on the eyelashes, to which the ointment had never been systematically applied, it must be noticed that the patient said she could never use it even to her eyebrows much, on account of its causing swelling of the eyelids. Thus it is really by no means impossible that the congestion which chrysophanic acid constantly causes did extend in some degree to parts which it did not actually touch. It is quite possible that it acts as an irritant rather than as a parasiticide.

For other facts which illustrate the results of treatment the reader may refer to Cases 27, 28, 29, 33. I may state that my treatment is very monotonous and almost always consists in the persevering use of chrysophanic acid ointment, the strength of which is raised according to the patient's susceptibilities.

Some Cases in which more than one member of the same family suffered.

Case 25.—Lady B—— brought me her two children, a boy and a girl, both of whom had patches which were perfectly smooth, shining, and could not be distinguished from common alopecia. Dr. Hancocke Wathen, of Clifton, who sent me the case, told me that exactly a year ago he had cured the children, by the chrysophanic acid ointment, of common ringworm. The hair had grown again quite well, and then, after an interval, had begun to fall, leaving perfectly smooth alopecia patches as described.

Case 26.—The cases of two boys named C—— are of some interest. The elder of these, aged 13, was brought to me with a most characteristic patch of alopecia, about the size of a shilling; the scalp was thinned and perfectly smooth. I could find no trace of fungus. A month later he had two other small patches of precisely the same character, and a month later still a younger brother, aged 9, was brought to me with a patch of similar character. There was no history of these children having had ringworm previously. But it was known that one of the servants in the house had been under treatment about six months ago for that disease. In both the boys, however, the patches displayed from the first, and retained throughout, the characters of alopecia, and not those of ringworm. There is a feature which is very characteristic of alopecia, and which readily distinguishes it from ringworm, which has, I think, not been sufficiently noted, and that is the remarkable thinning of the scalp which results from the falling out of the hairs. In this instance the children's nurse, who was an intelligent woman, remarked to me, "You can find the patches better by feeling for them than looking, for there is a dent in the skin." This was perfectly true, for the children having a thick crop of stout hair, it was very easy by the finger to detect the depressions caused by falling of the hairs.

Case 27.—A lady named Y——, aged 52, came to me in July of 1887, with almost complete baldness. She said that she had had an excellent head of hair until four months ago, when it began to fall in round patches on the back of the head. These had spread very rapidly, and already on some parts whitish downy hair was beginning to grow again. Mrs. Y—— told me, in answer to inquiries, that she had had ringworm when a child, and that her brothers and sisters had it at the same time. "It was in the village." Her father cured it, she said, by the use of an ointment which was employed for the scab in sheep. She said that they all got well much quicker than their neighbours' children who were under a doctor. A period of forty years had intervened between the occurrence of the ringworm and the appearance of the alopecia. The interest of Mrs. Y——'s case does not consist solely in its being an instance of ringworm in early life preceding alopecia in an adult. Another point of still greater importance is the fact that it had apparently been contagious. She brought with her her daughter, a young lady of twenty-one, in ex-

cellent health, in whom alopecia areata was just beginning. The patches were small but very characteristic, and after careful examination we could detect no fungus. There were no broken hairs upon them. The patches in the daughter had only been noticed a few days, and certainly had not developed until nearly four months after her mother's. It was known that she had used her mother's combs and brushes. The mother was almost bald. For both an ointment containing chrysophanic acid was ordered. I only saw them once or twice; but about a year later the mother brought to me another patient, and, with many expressions of gratitude, showed me that she had again grown a good head of hair. Her daughter also was, she said, quite well.

Case 28.—Miss G——, aged 22, was the subject of complete alopecia of the scalp. The history given to me was, that at the age of three she had some bald patches, and that her brother and sister caught it from her. The brother got well under treatment by blistering, but the sister is still liable to have bald patches recur, which are always cured by blistering. In Miss G—— herself the alopecia had been frequently recurrent. She had formerly been under the care of the late Mr. Startin, and had always found that his blistering restored the hair. More recently she had been under Sir Erasmus Wilson. About a year before I saw her, the hair, which had been growing fairly well, suddenly fell off again; and when she came to me, with the exception of a single tuft the size of a fourpenny-bit, she was absolutely bald. I was told that even in childhood, although the malady was distinctly contagious, it had never been called ringworm, and that the patches had always been quite smooth and shiny. Miss G—— was in good health, and had never suffered from headaches or from any material illness. Six months subsequent to the above note the hair on the scalp was growing again, but the eyebrows were falling out. This case seems to be a good example of a form of ringworm which from the beginning had all the features of alopecia, and which was subsequently, like alopecia, protracted into adult life, and attended by relapses.

Case 29.—Mr. McB——, a thin, slender man, aged 36, was under my care on account of alopecia, from which he had suffered for many years. He knew of no history of ringworm in his family; but a point of considerable interest to me was that I had attended an elder brother of his on account of alopecia areata. One of the brothers resided in Yorkshire, and the other had lived in Australia. They were nearly of an age, and as they had both developed, whilst in perfectly good health, this unusual form of disease, it seems to me a plausible supposition that they both had the seeds sown in boyhood by ringworm. The history of the case of my present patient was that his first patch occurred on the occiput, at a time when he was living in the Australian bush three years ago. He lost all his scalp-hair, eyebrows, and eyelashes, and for eighteen months had been under the necessity of wearing a wig. Finally, under the treatment of a quack, who used strong local applications, his hair grew again perfectly; that on his scalp was strong, but his beard and eyebrows were

always weak. He kept his hair for about a year, and when I saw him had been suffering for about six months from a relapse. His patches were as round and smooth as I ever saw them; thus the conditions of the relapse were exactly like those of a *de novo* case. He was in excellent health.

Alopecia after Fevers.

It would be of interest to note whether those who have suffered loss of hair as a sequel to fever are liable in after life to any peculiar forms of alopecia. The falling of the hair after fever is, I believe, always general, and not in patches; and when once it grows again, it usually, I think, grows strongly and remains vigorous. I was once myself quite bald, when a student, after an attack of typhus fever, and the patient from whom I was supposed to have contracted it, a young Irishman, became quite bald also. We both of us grew our hair again perfectly well, and retained it without any relapse. One of the last cases (Case 30) in which I had the pleasure of meeting the late Sir William Gull in consultation, was that of a gentleman aged 45, in whom alopecia areata, which had begun in a single round patch of a quite definite character, ultimately spread over the whole scalp, took away his eyelashes and eyebrows, and, I believe, every hair of his body. The interesting point in this gentleman's history was that he had, many years before, lost his hair after typhoid fever. So far as I know, in this case treatment was without result. The patient had several children, but there was no history of ringworm in his family, nor any known exposure to its contagion. He was in good health at the time. Through my friend Dr. Herman Weber I have obtained recent information as to this patient's condition (I have not myself seen him for several years). He has, since the failure of all measures that I could suggest, been under treatment in Paris, but still without success, and at present he has only a little thin colourless down on the back of his head. It may be reasonably doubted whether the after-fever loss of hair had anything whatever to do with the subsequent alopecia areata.

Case 32 is one in which the loss of hair was supposed to have been caused by fever.

Cases in which the Loss of Hair became general.

Case 31.—An example of the almost universal loss of hair, and of its growing again and falling again, was afforded in the person of a young woman who was under care at the Hospital for Skin Diseases, some years ago. Fanny W——, aged 25, gave the history that when she was twelve years old her hair began to fall in patches, and that she was soon quite bald. In the course of about three months she had lost not only all her scalp-hair, but her eyebrows and eyelashes, and in fact every hair that she had. None of her brothers, or sisters, so far as she knew, had suffered from it or from ringworm. She was under treatment for three or four years, and then desisted : it had several times grown again a little, and then fallen off. After two years without any treatment it began to grow again spontaneously, and grew fast. Her eyebrows were at first white, but subsequently regained their colour. During the next seven years she retained a good head of hair, but when she came under my observation at the age of 25, it seemed that the hair was again about to fall, all over her scalp. It was thin on all parts of the head, but there were many patches, some ill-margined, but others quite round.

Case 32.—Another example of complete alopecia, occurring under circumstances very similar to the preceding case, occurred in the person of a married woman, aged 26, who was under my observation in May, 1862 (Rosiana B——). She stated that in childhood, after fever and measles, she lost all her hair from the scalp and from her eyebrows and eyelids. Afterwards it grew repeatedly on the scalp in irregular patches, but she never had a good head of hair. The eyebrows and eyelashes never grew again, nor did the hair on the pubes, or in the axillæ. During one pregnancy her hair grew again a good deal, but fell again after delivery. When Mrs. B—— came under my observation she was quite bald, except for a few small tufts on each side of her head. She had not a single hair of eyelash or eyebrow.

Case 33.—A patient named G——, aged 30, consulted me on January 2, 1892, on account of absolute hairlessness. He had not a hair left on his body, but on using a magnifying glass, a little down could be detected on his cheeks. The history was that about three years ago a bald patch was noticed on his scalp, and that soon afterwards another came near to it. Not long afterwards, he noticed that his moustache was falling, and within a short time he had become quite bald, and had lost his eyebrows and eyelashes. He stated that the falling of the hair from his pubes, axillæ, and body generally, was extremely rapid, and that within a few months from the commencement of the malady he was quite hairless. From that time forwards no hair had grown, although he had had a good deal of treatment; he was a very florid man in perfect health. The history as regards ringworm was that his sisters had had it in childhood, and that he himself had had one or two patches, which he believed he caught from them at the age of 14. It did not appear that he had suffered at all severely. He was married, and had a child,

aged seven; neither his wife nor child had suffered. Just before coming to me, Mr. G—— had been to the special department of one of our large hospitals, and he narrated his experience as follows:—"They wanted to inject something called pilocarpine under the skin, but from the conversation I overheard I judged that it was an experiment, so did not go again." My own treatment consisted in the prescription of the usual chrysophanic ointment, and after six months' use of it the hair was growing over the whole scalp, whiskers, and moustache.

Case 34.—A young lady, Miss Alice T——, aged 22, was sent to me by Dr. C. E. Smith, of Manchester, in a condition of almost universal alopecia. She had lost her scalp- and body-hair, eyelashes, and eyebrows, but the latter had grown again a little. The history was that the hair had fallen in patches at the age of 16, and that it had from time to time grown again and again fallen off. There was, however, the important preliminary history that when at school, at the age of 13, she had suffered from ringworm. She had passed through a severe attack of typhoid fever, but it happened that this was one year after the beginning of the alopecia.

Case 35.—Dr. Corbet Fletcher, in the Camden Road, sent to me a man who had for four years suffered from alopecia, and in whom it had become absolutely universal. He was a brass-turner, aged 33, married, and in excellent health. None of his children had lost their hair. As to ringworm, he did not consider that he had ever had it, but he remembered hearing something about it in his family when a boy. In him there was the usual history that the disease had commenced by bald patches on the scalp, and had very rapidly spread over the rest of the surface.

Case 36.—Dr. Hough, of Derby, sent me some particulars as to a girl under his care, who had become almost hairless, and in whom all treatment had failed. He had elicited no history of ringworm.

Case 37.—Mr. F. C. Smith, of Cheltenham, sent me some facts as to a case in which a patient lost hair from all parts of his body. It had begun as an ordinary form of alopecia in patches on the scalp, and had been three or four years in progress. All treatment had failed to stop the falling of the hair, and that of the eyebrows, beard, moustache, and all parts had been lost. Mr. Smith's patient was a man, by trade a farrier, and one in whom, therefore, it is very possible that contagion from an animal might have occurred.

Case 38.—A gentleman named G——, who wrote to me from Derby, described a condition of absolute hairlessness, which had existed for three years. He said that he was in perfect health at the time that the hair began to fall, and that within three months he had lost every hair of his body. After long perseverance in a variety of treatment he had succeeded only in getting a very few fine hairs on his head and face. His hair had originally, he said, been very strong and plentiful. No facts were given me as to ringworm.

Case 39.—Dr. Wales, of Belfast, consulted me about a lady who had lost all her hair. She was about forty years of age; the hair had sometimes grown again, and then again fallen. The point of interest in the case was that she was the subject of intermittent glycosuria.

Concluding Remarks.

It will be seen that amongst the cases which I have related there are many in which the evidence was quite clear that ringworm had preceded the alopecia. There are also some in which no proof of such connection could be produced. There are several in which two members of the same family, who had suffered at the same time from ringworm, became subsequently the subjects of alopecia. In several instances the history of the original attack of ringworm was, in the first instance, denied by the patient, having been either not known or forgotten, but was subsequently supplied. The cases are a fair specimen of my personal experience during the last few years in reference to the disease in question, and their results will, I suspect, differ only from those of other observers in that, being specially interested in the point, I have been more patient than usual in seeking for the history of ringworm. Much patience is indeed necessary on this point, for I have found that almost invariably the first answer to the question, "Have you ever had ringworm when a child?" is in a strong negative. Some patients have quite forgotten it; some never knew what the disease was; some doubted the diagnosis; and one and all are very willing, if they can, to ignore the fact. Inquiries on this head must be expected to give negative results in hospital practice far more frequently than amongst private patients. The latter are more intelligent as to their antecedents, and can usually inquire at home as to what happened in their youth, with much better hope of success. I freely admit that in a very considerable number of cases, even after painstaking inquiry, no history of antecedent ringworm is forthcoming. These cases, however, do not shake my belief in the creed that alopecia areata is a disease in connection with cryptogamic growth. I suspect that some of them are examples of direct contagion from alopecia itself; others of contagion to the

heads of adults from ringworm in children; and, lastly, others of contagion from pityriasis versicolor. Concerning the latter malady, I have no doubt that it is transmutable with ringworm. My theory respecting alopecia is that it is due to some form of cryptogamic life, which develops deeply in the hair follicle, and does not grow in the hairs themselves. I admit that this cryptogam has not yet been satisfactorily identified by the microscope, and that in the majority of cases the most careful examination will fail to give any indication of its presence. Alopecia areata is, however, a disease of such definite features, and of such remarkable sameness in its clinical history in different cases, that it is extremely difficult to entertain the belief that it depends on one cause in one case and upon a totally different one in another. I cannot but think that its cases ought all to be placed in one group, and since the evidence is so strong that some of them depend on antecedent ringworm or upon direct contagion, I cannot escape the conviction that they all do so.

There are certain other facts which favour the belief just expressed. Thus, although alopecia but rarely exhibits contagious properties, it sometimes does so. Many authors have recorded instances in which it affected several members of the same family, and more than one series of facts are on record in which it prevailed as a household epidemic.*

* By far the best example of epidemic alopecia with which I am acquainted was recorded in the *Boston Medical and Surgical Journal*, May, 1892. I am indebted to Dr. Richmond Leigh for a detailed abstract of this important paper. It occurred in an orphan asylum for girls, and no fewer than sixty-one out of sixty-nine suffered. The first case occurred in January, the second in March, and between the latter date and June 1st the total of sixty-one had been completed. The matron and four older girls who acted as her assistants escaped. Dr. Bowen and Dr. J. C. White, both of Boston, and distinguished dermatologists, saw the cases, and both agreed that their general features were indistinguishable from those of alopecia areata, and both failed, on microscopic examination, to detect the presence of any cryptogam. The hair-bulbs were wasted, as in alopecia. The bald patches are stated to have been smaller and more numerous. No preceding stage in the least resembling ringworm had been observed in any of the cases. Most of the cases were getting well in the course of a few months, and it was not thought that the cure was due to the use of any particular remedy. On this point, however, there is much room for fallacy.

The entire absence of any form of ill-health in the subjects of alopecia areata induces me to put wholly aside any inquiry on that score. We may, I think, entertain absolute incredulity as to what is called the neurotic form of this disease. It attacks young people more frequently than others, and they are usually those in whom neither headache nor any species of neurotic disturbance had been observed. It does not appear to me to be worth while in such a malady to ask an adult patient as to overwork, mental worry, and the like. Such influences may be found, if sought for, in the majority of those who consult us, and I feel very certain that when they chance to be coincident with alopecia they do not stand to it in the relation of cause.

The mode in which alopecia develops, the frequent, or indeed usual, absence of bi-lateral symmetry, and of any definite uni-lateral asymmetry, the rounded form of its patches, and their tendency to enlarge serpiginously, are also, I think, conclusive evidence as to its not being of neurotic origin. We know of no neurotic malady which has round patches that spread at their edges.

Lastly, I may allege that the modes of cure in alopecia areata by chrysophanic acid, creosote, blistering, &c., are all in favour of the belief that it is a disease of local origin. So also the facts that it always begins as a single patch, and, when it becomes general, spreads by the development of other patches from the parent as a centre, favour the belief in its cryptogamic nature. The facts as regards the occasional regrowth of hair, and, after an interval, its falling off again, are very curious. They are not susceptible of satis-

Whatever opinion we may incline to entertain as to the name which we should apply to the disease in this very remarkable outbreak, it appears to prove, beyond dispute, that there may occur a form of alopecia in patches which is actively contagious, and yet is unattended by any fungus which the most modern methods of research can demonstrate. The narrative may be placed side by side with those respecting certain other maladies, not usually virulently contagious, but which may by a sort of accident become so. I allude to epidemics, of pemphigoid porrigo, such as those described in ARCHIVES, Vol. III. p. 206, to those of puerperal fever, as related by the late Mr. Storrs, of Doncaster, and to those of epidemic eczema in workhouses, which have recently claimed much notice in my pages.

factory explanation on any theory that I am acquainted with, but they fit more nearly with some facts that have been established as regards cryptogamic life than with any other hypothesis.

Summary.

I may venture to offer the following conclusions as a summary of my present belief in reference to alopecia areata:—

1st. It is probable that all the cases which are well characterised, by abruptly rounded and quite smooth patches, are of one and the same nature as regards causation (possibly there is some slight exception to this in reference to syphilis).

2nd. It is probable that all cases of well-characterised alopecia areata are in some connection, remote or direct, with the presence of a cryptogam.

3rd. Many cases, probably the majority, occur in patients who have, at some former period, themselves suffered from ringworm.

4th. A few cases occur to those who have never shown signs of ringworm, but who have, at some former period, been exposed to its contagion. Some cases occur to adults as the direct result of ringworm-contagion from children.

5th. In a few cases it is possible that pityriasis versicolor, on the chest of an adult, may be the cause of alopecia areata on the scalp.

6th. There are a few cases in which ringworm assumes, from the first, the features of alopecia areata. These may occur both in children and adults.

7th. Lastly, the explanation of the frequency with which alopecia areata begins on the back of the head is probably that it is caught by contagion from the backs of chairs and cushions, &c.

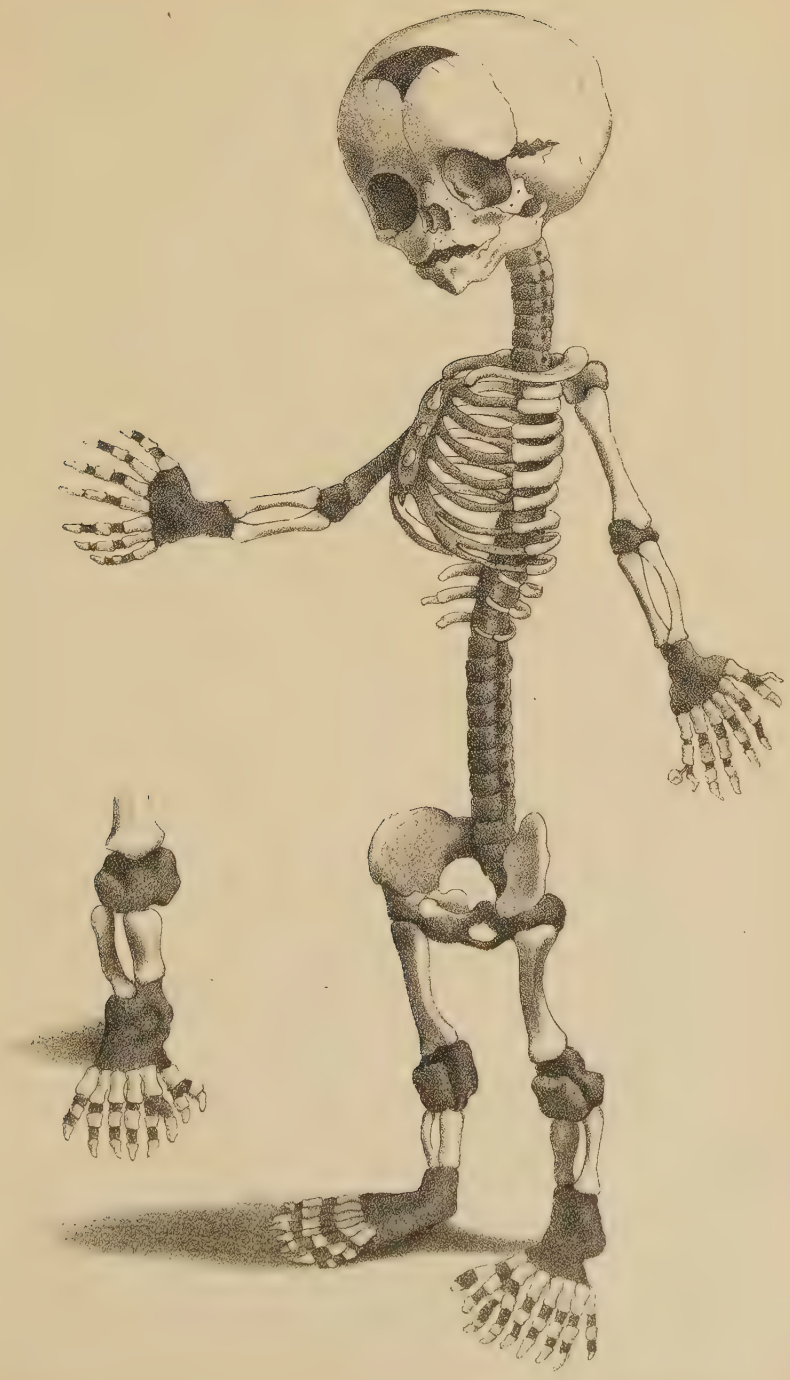
PLATE XCII.

A SHORT-LIMBED POLYDACTYLOUS DWARF.

This quaint figure is copied from Theodore Kerckring's 'Spicilegium Anatomicum,' published in Amsterdam in 1670. The description states that the body was that of an infant found drowned in the river on Oct. 16, 1668. It was dissected by the renowned Ruysch. A detailed description of the skeleton is given. My reason for now reproducing the Plate is that it offers an important item of evidence in reference to the development of short-limbed dwarfs. Although we must not place too much reliance on the accuracy of the draughtsman, since he has figured some superfluous lumbar vertebræ, yet there can be no doubt that the limbs are much too short for the trunk and head. This remark especially applies to the lower limbs and pelvis. These are exactly like those of the Norwich dwarf, and of the skeleton in the Heidelberg Museum which I described in a recent number of the 'Archives.' The point of extreme interest in the present case is that this dwarfing of the limbs is associated with polydactylism. Both the hands have seven digits. The right foot has eight and the left nine. The conditions are not exactly symmetrical, since in some instances a metacarpal or metatarsal bone is wanting; or, to put it otherwise, two are welded together. It will be seen that the upper extremities are so short that the tips of the digits will only just touch the iliac crests.

This occurrence of short limbs with polydactylism seems to prove conclusively that the condition may be due to a modification of development of a totally different nature from rickets. It is probable that the infant was not at full term. Amongst the points which the author has noticed in his description are—that the fontanelle was double its usual size; that the orbits were somewhat deformed; that the two halves of the lower jaw were already united; and that the ribs were short and badly formed.

He also, of course, draws attention to the shortness of the limbs, the stoutness of the long bones, and the supernumerary digits. I find no statement that the skeleton was deposited in any museum, but it is very possible that it is still in existence in Amsterdam, and if so, it is very desirable that it should be more exactly described.



West, Newman, lith.

CONGENITAL DEFECTS AND INHERITED PROCLIVITIES.

Various defects of development in the same subject.

All facts bearing upon the combination of defects in development are of importance. I have just seen a boy of nine, upon whom, when he was an infant, I had to operate for hypospadias with pin-hole orifice. The glans penis is bent downwards, and the penis itself very small. This boy has since been the subject of what may be called an incomplete descent of the testicles. Although he is now nine, the scrotum is usually empty: the testes can be drawn down to the bottom of it with the greatest ease, but they never remain long there; in order to keep them down he has for some years, on the advice of another surgeon, been wearing a double truss. This boy has peculiarities in the formation of his head. The anterior fontanelle was very long in closing; his forehead is rounded and very large, and a deep transverse furrow crosses the skull almost from ear to ear. His lower jaw has not grown well—it is distinctly too small for the rest of his head, and his front teeth are much displaced by crowding. His incisor teeth in both jaws are perfect in formation, but in both the canine shows a curious notch.

Defects in the Ulnar Digits—Inheritance in three generations.

Dr. Potter, of the Kensington Infirmary, was good enough to show me an old woman, named Elizabeth Collins, in whom deformity of the hands by suppression, &c., was distinctly a matter of inheritance. She knew of its occurrence in at least three generations, her mother and her mother's father having

had hands, as she believed, much like her own ; one of her sisters also (one of seven) had deformed hands.

In her *right hand* there was but little defect visible ; she had the normal number of digits, and none of them were much dwarfed. That there was, however, a tendency towards the condition presented by the left hand was clear, for the middle digit was smaller and shorter than either the index or ring, and both the ring and little finger had their terminal phalanx flexed.

In *both hands* the thumb and index finger were normal, the three ulnar fingers alone being deformed.

The left hand. In this hand the second and terminal phalanges of the ring finger were duplicated, exactly as if there had been bifurcation of the first. These twin digits were of almost equal size, and firmly united by a fleshy web ; on each there was a good nail. The middle finger was small, and shorter than the index. The bifurcated finger was also shorter than natural. The little finger was of normal size, but showed an exceedingly small nail, and was crippled by flexion of the second phalanx on the first.

It will be seen that this case bears some resemblance to that of the man whose hands I shall next describe, in that the chief defect of development falls on the ulnar half of the hand. Neither of the patients had any defect in the feet. In the case of the woman the index and thumb had entirely escaped in both hands, but in the man they were webbed in one.

Congenital bilateral defect, by suppression, in the development of the Ulnar Digits.

The subject of the deformity which I am about to describe was an old man in the Kensington Infirmary. I am indebted, as in the preceding case also, to Dr. Potter, the resident physician, for an opportunity for examining him. His hands presented a very remarkable example of deformity by suppression, in association with over-growth. He was not aware of any history of similar defects in his family, but on this point it is very possible that he was not well-informed. The state of his

hands had through life precluded him from any better occupation than that of hawking in the streets. His two hands, although not exactly alike, showed a tendency to defects of the same character. In each the thumb and index-finger were of normal size, and the other three fingers were dwarfed or omitted.

In the *right* hand, five metacarpal bones could be easily recognised; but the middle finger was absent, its metacarpal bone ending just short of the knuckle. The extremity of this bone was movable, and as sharply defined as if it had been amputated just below its head. It was as large as the others (suppression of the epiphysis and digit). The little and ring fingers were united and were short. The index and thumb were also united.

Left hand. In this hand the middle finger was wanting, together with its metacarpal bone. The little and ring fingers were united at their base and were of large size; in each the second and third phalanges were flexed. In this hand he had only three metacarpal bones.

Superfluous Thumb on one hand—History of the same deformity in the same hand, in a single individual, in three generations.

Amongst the patients that Dr. Hopkins showed me at the Cleveland Street Sick Asylum was an old man with a duplicate thumb on his left hand. The superfluous digit was in front of the normal one, and was curved over its base; it was small, but complete as regards its phalanges and nail. A most interesting point in the case was that the man knew that it had occurred in three generations at least—his own father, himself, and one of his sons: it had always been on the left hand. He believed that in each generation only a single individual had displayed this malformation, and that all three had shown it in exactly the same condition. I thought that he had a little thickening on the side of the thumb of his opposite hand, and that it was broader than usual, but he himself explained this by saying that it had been injured.

Congenital absence of the Ulna and its Digits.

There are few surer ways of obtaining knowledge than to candidly avow ignorance, and I have repeatedly found that a statement that I had never seen an example of any given condition is an almost certain means of bringing some such to light. In a recent number of my ARCHIVES I said that I had never seen an instance of congenital absence of the ulna, and that I did not know of any recorded. I was familiar with Forster's work on malformations, and with the catalogues of most of our museums, none of which contain any reference to such. It chanced, however, that at the very time I was writing the paragraph referred to, Dr. Hogarth Pringle, of Glasgow, had under his care an example of this very rare malformation. Dr. Pringle's industry has also unearthed the record of two other cases. Suppression of the ulna and its digits, therefore, now takes its place by the side of suppression of the radius, although, for some reason as yet unexplained by teratologists, it is far more rare. Dr. Pringle's cases are the following:—

1. His own case. A woman with entire absence of ulna in both forearms, and ankylosis of the radius to the humerus at elbow. Upper extremities short and small, and two digits absent in both. It was difficult to feel certain as to which digits were represented by the three which remained, and not improbably one thumb was absent and the other dwarfed. It was clear that it was not an instance of definite suppression of the ring and little fingers. Full details will be found in Dr. Pringle's paper in the "Journal of Anatomy and Physiology," vol. xxvii.

2. A case recorded in 1696 by Göller, in which a seven months fœtus was born with bilateral absence of ulna and of four fingers, only the thumb being present. In the lower extremities the fibulæ were absent, and only the great toes remained.

3. An old man described by Dr. Roberts in the thirteenth volume of Transactions of the Pathological Society of Philadelphia, in whom there was absence of right ulna, and of third, fourth, and fifth digits. In the left extremity the ulna was

present, but the third and fourth digits and third metacarpal bone were wanting. It this instance two predecessors had had stiff little fingers. A sister and niece were reported to have each one hand like those of the patient, and amongst his own children, of whom there were seven, three had malformed hands like their father's.

Dr. Pringle mentions a fourth case, but in it only the middle third of the ulna was absent, its carpal extremity and its digits being perfect.

Diffuse Ichthyosis in a case of Consanguineous Marriage: three children affected.

The case which I have next to relate is an instance of the family form of ichthyosis, in which it was possible, in the first place, that it was an inheritance from eczema, and in the next that the tendency had been intensified by a consanguineous marriage. The patient was a boy of fourteen, one of a family of seven, the offspring of parents who were first cousins. No children had been lost, and the whole of the seven were in good health, and several of them remarkable for athletic vigour. Three, however, were in a mild degree ichthyotic. The family consisted of three girls and four boys, and two of the boys were twins. It was the twins and another brother who suffered from the skin-affection; all the girls had escaped. I did not see the girls, but was assured that they were well-grown, and, excepting a little chest-delicacy in one, models of health. The patient whom I saw was the worst of the three ichthyotic cases, and his condition, although definite, was by no means severe. Of the two whom I did not see one was said (by his mother) "to have no pores to his skin," and to be almost wholly incapable of perspiration; the other was described as having simply a dry, rough skin. They had suffered so slightly that their father, who was present when I took the history, said he had never known that they ailed anything. Their mother knew, however, and said that the peculiarity of the skin had in all three been recognised during the first few months of infancy.

The boy whom I saw was in every respect well developed, with the exception of his skin. The affection of the latter

consisted in general harshness and dryness, with the addition on certain parts, especially on the outside of the thighs, that the orifices of the hair-follicles were prominent, causing a permanent state of cutis anserina. The only parts of the surface which were soft and unaffected were the armpits, the bends of the elbows, and the popliteal spaces. The parts where the skin was most rough were those usually affected in psoriasis, *i.e.*, the elbows, the lines of the ulnæ, and the fronts of the knees: on the latter parts the condition was very like that of diffuse psoriasis. The face was very slightly affected, being just a little branny, but it showed a large number of little pigmented moles. The prolabia were desquamating, and were, I was told, very liable to peel and get sore in cold weather. There was a history that he had, on several occasions, had an eruption of spots, or possibly patches of eczema, superadded to his ichthyosis; but of this there was no trace when he came under my observation. The state of his skin gave him very little inconvenience.

As regards family history, I might very easily have put on record that there was none whatever, for it was only after repeated inquiries, resulting in the confident assurance that there was "no skin-disease in the family," that the father remembered that two of his own sisters had long had "gouty eczema," but "that," he added, "is only gout, you know." When we remember that these two ladies were the own sisters of the boy's father, and first cousins of his mother, I do not think the suggestion will seem without probability that the predisposition to skin-disease was intensified by the consanguineous marriage. Those, however, who hold that these marriages lead directly to degeneration of the stock cannot find any support for their views in this instance. The marriage appears to have been a very happy one, and the parents were proud of their seven children, who were, with the single exception described, all perfectly developed and perfectly intelligent.

A case illustrating congenital and hereditary susceptibility of skin.

In the case of a gentleman named A—— H——, a

surgeon, who had the borders of his ears eaten away by chronic chilblains, or sunblains, we had a remarkable fact in proof of family liability. He remembered that his father suffered from the same, and to such an extent that he used to wear earbags in order to protect the parts from chilling. The inheritance in such cases consists probably in a peculiarity of tissue vitality. It is possible that this may be assisted, or rather aggravated, by a peculiarity also in the vigour of circulation, permitting easily, under the influence of cold, of arterial contraction, an approach to "Raynaud's phenomena." It may be suspected, however, that susceptibility of the solid tissues has more to do with it than susceptibility of blood vessels, although the two are almost always associated. Heat as well as cold, and in many instances much more efficiently, will cause these forms of ulcerating blains. (See ARCHIVES, Vol. iii.) The phenomena of chilblains are more nearly allied to inflammation than to arterial spasm.

In the case which I have mentioned above there were some other very peculiar conditions which favoured the supposition that the patient had inherited a peculiar susceptibility to local irritations in the whole of his skin. He came to consult me, not on account of his ears, but on account of a very peculiar eruption on his legs. Of this he had had several attacks, the first having occurred ten years ago during hot weather in New Zealand, and the last during the present summer while staying at an English seaside place. On each occasion a number of erythematous blotches had appeared very suddenly on his limbs, affecting the backs of his hands and his legs especially. They had never come out quite symmetrically, but usually in groups, and sometimes only on one limb. Their onset had been so sudden on at least one occasion, and attended with so much irritation, that he thought he must have been stung. He showed me on his right leg a number of discrete spots the size of split peas, and almost black with pigmentation. They had been present for several months.

I encouraged Mr. H—— to believe that his very peculiar eruption was purely of local origin, and that it had probably

on each occasion resulted, as he had at once suspected, from the bites of insects. The condition of his ears demonstrated remarkably the susceptibility of his tissues, and very probably mosquitoes, fleas, gadflies, and the like, when they attacked him produced results far more severe than they usually do in other persons. His eruption, it should be said, had on each occasion lasted several months. There was a history both of tuberculosis and of gout in his family, but I do not know that either, or especially the latter, had much to do with his symptoms.

Inherited liability to Raynaud's Phenomena, with great proneness to Chilblains—Gradual increase of liability to paroxysmal local Asphyxia—Acro-sphacelus with Sclerodermia—Cheeks affected.

Mrs. B——, aged about 50, is a tall, thin woman, in very good health with the exception of what I am about to describe.

She was sent to Aix-les-Bains nine years ago for rheumatic gout in her hands, and sciatica. It was there that the state of her hands was first noticed, "the tight state of the skin." She has been a martyr to chilblains, and as long as she can remember. Almost from childhood she has noticed her fingers to die and become white. Her mother was all her life liable to dead fingers, and "never came down to breakfast without some of her fingers white and tallowy."

Mrs. B—— at present date (Oct. 6, 1892) has gangrene of the end of the left forefinger, and she tells me that she has formerly suffered from the same in several other fingers.

Her feet have suffered like the fingers. The abscesses in the tips of toes began two years ago. Electricity was used a whole winter without the slightest benefit. She wintered last year at the Canaries and was no better. Her face is board-like and much freckled, with some stigmata. Her ears have not suffered, nor the tip of nose. Her nose is much less stiff than her cheeks. She has frequent paroxysms (Raynaud's phenomena).

She easily gets diarrhœa. She tells me that whisky and water does not make her flush in any special degree, but she takes very little. Port wine suits her, but it gives her gout.

Mrs. B—— had on the whole enjoyed good health through life. She appeared very cheerful, and assured me that no mental distress or shock had preceded the development of the disease. She had no family, and had been accustomed to all the comforts of life. She was accustomed to take much horse exercise, and said that she could still manage her bridle with her left hand.

Amongst the points to be specially noted in this case are the following:—It forms one of the most definite connecting links between Raynaud's disease and diffuse sclerodermia that I have ever seen. The paroxysmal changes in the condition of the fingers has been very marked indeed. Thus her fingers may die and recover again several times in the day. When she came into my room one forefinger was quite white, while all the others were red. In the course of ten minutes, however, this finger had become red also. This tendency to paroxysmal variation of condition is the essential character of Raynaud's malady, and is much less marked in ordinary cases of sclerodermia, or may not be noticeable at all.

My object in adducing in the present series the last case is to draw attention to the fact that the liability to Raynaud's phenomena is often, indeed I believe usually, a matter of inheritance. I could cite several other cases in which a daughter presented exactly the same symptoms as her mother had previously done. In a paper on Acro-pathology which I have recently published in the *Semaine Médicale*, I have advocated the view that the phenomena in question are, to a large extent, the result of congenital organisation. As regards the coincidence of sclerodermia with Raynaud's malady, I may briefly say that although we now and then see them together, their connection is by no means essential.

ON CERTAIN DISEASES OF THE TONGUE.

The Earliest Stage of Cancer of the Tongue.

A PATIENT whose tongue I had sketched in January, 1893, as an illustration of the very earliest stage of cancer, afforded a good instance of the very insidious manner in which malignant processes sometimes originate. This man had been for some months under the observation of one of the most careful diagnosticians in London, and had been assured, only a few weeks before I saw him, that there were no indications of cancer. His tongue presented a good example of white-paint-sclerosis. He had suffered from syphilis thirty years ago, and had been in the interval an inveterate smoker. There was certainly nothing in the appearance of his tongue which, according to our old notions of diagnosis, would have raised the slightest suspicion of cancer. There was, however, a patch on the dorsum, not very far from the tip, from which the white-paint thickening had cleared away. This patch was about the size of a shilling: it was not in the least ulcerated, and was scarcely raised, but it was firm to the touch, and it presented over its whole surface a minutely granular appearance. It was like a portion of cauliflower buds on a very small scale, and flattened down. I could not feel any doubt that it was really the first stage of epithelial cancer. I was told that it had considerably increased during the last two months. On examination of the floor of his mouth I could detect, near the angle of the jaw, two slightly enlarged glands. I of course advised the immediate excision of the whole tongue.

The Pre-Cancerous Stage of Cancer of the Tongue.

On the day following that on which I saw the preceding

case, another presented itself, in which the symptoms were on a yet smaller scale. They were, however, precisely similar. The little sore was on the left side of the tongue, not far in front of its base. It was not so large as a threepenny-piece, and it is an exaggeration to call it a sore, for it was detected by the eye with some difficulty. On applying the fingers to the two sides of the tongue, however, it was quite certain that whilst on the sound side the structures were soft, on the other there was a little disc of induration. About this my son, who saw the case with me, was equally assured with myself. The surface of this indurated patch was minutely granular, and the sore spot had been the seat of a pricking pain which had made the patient anxious. This sore was in exactly the same place, and in all respects exactly similar to one which I treated many years ago in the person of M. N——, himself a surgeon. In that instance we were both of us for some time very anxious about cancer. By repeated applications of the caustic acid nitrate of mercury, very liberally used, we succeeded, however, in getting rid of the growth. M. N—— lived many years afterwards, and had no further trouble with the sore. The satisfactory result of that and some other similar cases encourages me to venture upon a similar plan in this instance, and to abstain for the present, at least, from the more radical method of excision.

Note.—Since the above was written I have made three applications of the acid, and with the result that all induration has disappeared; and that, for the present at least, all anxiety has ceased.

On a rare Eruption on the Tongue to which the term "Symmetrical Filmy Patches" is applicable (true psoriasis of the tongue).

There is a condition of the tongue of which I think the term "symmetrical filmy patches" is perhaps as descriptive as any that can be suggested. It is, I believe, an example of an eruption on the tongue, and is not due to any local cause, nor in any way influenced by such. Its symmetry indicates that this is its nature, and its occurrence not infrequently in association with disease of the skin gives support to the sug-

gestion. Its recognition is of great importance, since it may easily be mistaken for a symptom of syphilis, although it has, I believe, nothing whatever to do with that disease. I am not now describing "the filmy patch" for the first time. I first noticed these patches in several cases of lichen planus, and I described it in my Lectures published in the year 1880. My friend the late Dr. Sparkes, in conjunction with Dr. Bruce, had previously described a very peculiar group of white bodies on the tongue in a case of pityriasis rubra. They were, however, on one side only, and showed as boldly defined tubercles, about the size of a split pea. This description by no means fits with the patches which I am now describing. In some cases the symmetry is not quite complete, inasmuch as the patches are larger on one side than the other; but, so far as I have seen, there is always a very definite tendency to bilateral arrangement. The patches which compose the groups are often somewhat irregular in form, and although more or less rounded, are seldom accurately so. They may vary in size from a pin's head to a split pea, or to a threepenny-piece. They are never seen in the middle line of the dorsum, but always arranged in a long streak, one on either side. Now and then there are some white patches under the tongue as well, and not unfrequently there are spots in the mucous membrane of the cheek. These patches are to be carefully discriminated from those of superficial sclerosis, so commonly seen in smokers, more especially in smokers who have previously suffered from syphilis. In the latter the patches are almost always ill-defined, and their formation is preceded by baldness from destruction of papillæ. As a rule, in the condition of sclerosis no papillæ whatever can be distinguished. In the disease which I am endeavouring to describe the papillæ are not wholly destroyed, but are glued together and covered by a thin, whitish, semi-transparent film. Through this film the fungiform papillæ are often easily seen. There is scarcely any thickening, since a partial atrophy of the papillæ makes up for the new formation on the surface.

As regards the class of patients who are liable to the filmy patches, I believe they will usually be found to be in excellent

health, and wholly unable to assign any cause for the condition of the tongue. The patches do not produce any inconvenience, and I believe that they may pass away without leaving any permanent change. I have seen them more frequently in men than in women. I possess several drawings illustrating this disease; but before referring to them I will describe a recent case in which I have recognised their presence. It was a very well-marked example of the disease.

A gentleman, aged 36, who had been married ten years, and had healthy children, sought advice on account of the condition of his tongue. He had been for some months under treatment, and had been using chromic acid. Suspicions had also been expressed that the condition was syphilitic. It was an excellent example of the filmy patches. On each side of the central line, not far from the tip, was an irregular rounded white patch, as large as a threepenny bit, and from this others extended backwards in a line on each side, midway between the middle and the edge of the organ. There were some extremely slight patches in the cheeks. The patient had never had syphilis, and he had no stopped teeth. He had never suffered from any form of skin disease. He had formerly been a smoker, but had left off three months before I saw him, and without any benefit to his tongue. He told me that the patches had come out rather quickly, and at several places at once. This was five months before I saw him. On looking carefully at the patches with a magnifying glass, the appearances suggested a thin layer of whitish size, spread over somewhat shrunken papillæ, and smoothing them down. On the most careful inquiry I could find nothing either in the patient's state of health, or in his habits as regards local irritation to explain the condition. Amongst other cases in which I have recognised this disease I may mention the following:—

A gentleman, aged 44, whose case is given on page 212 of my Lectures, had these patches in association with a copious eruption of lichen planus. Under treatment by arsenic the tongue got well before the skin, but both were in the end quite cured.

A gentleman named L——, aged 48, presented the condition

described. In addition to the symmetrical patches on the tongue, there were white-edged, map-like patches on the pouches of the cheeks. He had never had syphilis, and smoked but very little. He had no skin disease, but his nails were somewhat fluted lengthwise and rather rough at their roots. The patches had been noticed for about eighteen months when I saw him in May, 1885. I do not know anything as to the further progress of the case.

Filmy Patches on Tongue without obvious cause, but in association with liability to Urticaria.

A remarkable example of what I have sometimes called the filmy patches on the tongue, those which occur with lichen ruber, was brought to me by Dr. Hack Tuke, his cook being the patient. They were symmetrically placed, two on each side, about midway on the dorsum, and exactly resembled those depicted in one of my drawings. The patient believed that they had been present only a few months. She was brought to me not on account of the tongue, for indeed it had not attracted any notice, but on account of a very troublesome irritability of the skin. From this she had suffered for many years, and it appeared from the descriptions given to be a sort of urticaria. There was nothing to be seen at the time she was with me, but I was told that she was often kept awake at night by extreme itching of the whole surface, and that wheals and long streaks of redness would show themselves. I was told that the eruption was specially prone to occur round the waist where the strings of her dress pressed, which is so often the situation affected in lichen planus. The patient was a healthy-looking young woman of about five and twenty.

Chronic Glossitis, with films chiefly on the sides of the Tongue, and possibly due to amalgam tooth-stopping.

The condition of tongue presented by Colonel D—— was somewhat peculiar. He had no abrasions or ulcers, with one very trivial exception; but the whole border of his tongue on both sides was abnormally smooth and red, presenting

at almost regular intervals little ill-defined patches of white film. These films could not be detached; they were especially conspicuous near the tip. On its surface the tongue was clean, rather too smooth, that is the papillæ less conspicuous than normal. The tongue was not indented at its edges, but the little white films seemed to correspond with the intervals between the teeth. Similar slight films were beginning to form just inside at the corner of the mouth (smoker's patches). Colonel D—— had been under treatment by his family attendant for upwards of a year, but his tongue had been getting worse rather than better. He had been chiefly treated for dyspepsia. The problem was to find a cause for his chronic glossitis. He appeared to be in excellent health, and of late he had smoked exceedingly little. In early life he had smoked heavily. He had never had syphilis, and he scarcely ever drank effervescing drinks. His teeth were in very good condition and very carefully attended to; many of them had been stopped, some with gold and some with amalgam. He thought he had had the amalgam in some of them for upwards of twenty years. The soreness of the tongue had only come on during the last year or two, and as he assured me he did not smoke a cigar oftener than once or twice in a month, I was driven to suspect that the amalgam stopping might have something to do with the glossitis.

Examples of Neuralgic Pain in Tongue, possibly due to Gout.

There is a definite group of cases in which patients complain of pain on one side of the tongue, just in front of the pillar of the fauces. The part affected is only brought into view when the tongue is put out to the uttermost. In this position there exists naturally a series of vertical ridges which are larger in some persons than in others. Patients who become subject to soreness or pain in this position almost always find out these ridges, just as others discover the papillæ circumvallatæ, and in each case mistake them for the beginning of cancer. Sir James Paget has, I believe, drawn attention to the occurrence of pain in this particular part of the tongue, and has associated it with gout. It has

occurred to me to have to treat several very troublesome examples of it, and in more than one there was some definite hypertrophy of the folds in question, with appearances which made me apprehensive that cancer might really be beginning. One of my patients in this category was himself a distinguished surgeon, well cognisant with the early stages of cancer, and for upwards of three months neither he nor I could venture to feel quite certain that the condition was of no importance. There was no actual ulceration, but there was pricking pain, slight hypertrophy, and, as compared with the other side, a little induration. The pain was constant and troublesome. We made repeated applications with the caustic solution of the acid nitrate of mercury, and in the end succeeded in getting rid both of the pain and of the local changes. In this instance there was no proof of gout, but it was still very possible that a tendency to it existed.

In the case of a florid widow lady, aged about 60, whom I have seen at intervals during several years, precisely the same conditions as those just described were present, and I have adopted a similar treatment. In her, however, there is no room to doubt that a gouty tendency does exist. She has had pain in the smaller joints, and frequently passes uric acid. The pain in the tongue has often seemed to be relieved by the use of alkalies. As there has been almost from the first decided thickening and even a slight tendency to ulceration, I have not felt justified in trusting gout remedies, but have repeatedly and freely cauterised the parts. She has been on one occasion quite free from pain for a year, and then at the end of the time returned to me with the same complaint.

A third case was brought to me last year by Mr. Oliver C. Maurice, of Reading. In this case the patient was younger than any of the others, being not more than forty. The symptoms were exactly the same, a frequently recurring pricking pain in the side of the tongue, and a slight hypertrophy of the folds in question. There was, however, nothing at all definite as indicating cancerous ulceration.

I have seen a good many of these cases in which there was pain only, and no proof whatever of local change, and in most of these the patient's age and history might quite support

Sir James Paget's statement that the affection has its origin in gout. Remembering, however, the extremely insidious manner in which cancer often begins, and holding strongly the opinion that its first stage is in many instances a form of inflammatory hypertrophy, I have seldom felt able to tell the patient that it was safe to wholly disregard the symptom. Such patients are almost always at the cancerous age, and although it is right to allay their fears as much as it is possible, it is at the same time necessary that the case should be kept under observation. The pain is fortunately in most instances sufficiently definite to ensure this. As regards the precise character of the pain, it is sometimes described as a dead ache, and sometimes as the pricking of needles, and it is often attended by a bitter taste on that side of the mouth. Careful attention should, as a matter of course, be given to the state of the teeth near to the painful part of the tongue. Not only should they be examined as to any roughness which may be present, but also as to any amalgam stopping. I feel sure that such stopping not infrequently causes a bitter taste in the part of the mouth nearest to it, and believe that it not infrequently originates disease in the tongue.

A footman, aged 59, had suffered for three years from what he called a sore tongue. He had tried the patience of several surgeons before I saw him; there was nothing whatever to be seen, and yet, as he alleged, his life was made a misery to him by a constant sense of soreness in the tip of his tongue. He compared it to "a red-hot ball," to "a whitlow throbbing in the finger, as if a wasp had stung me and it was swollen up," and had other similes, all expressive of severe pain. He said that he was constantly seeking a comfortable place in his mouth for his tongue and trying to cool it. I could find nothing, excepting that the median fissure was at the top a little more marked than usual, and that the papillæ near it were pointed and red. There was no ulceration. The pain complained of had been present more or less for three years.

The patient was a healthy man, and although a butler, it was in a teetotal family, and he had never had access to wine. He had taken stout and beer regularly, but never in

excess. He had never been threatened with gout, nor was gout known to have occurred in the family.

I applied the acid nitrate of mercury very freely to the cleft in the tip of the tongue, and ordered aconite and alkalies.

In this case, as in others, the pain passed up the *left* side of the tongue.

SYPHILIS.

No. XLV.—*A Case in which it would appear that Primary Syphilis was communicated in marriage more than two years after the original disease.*

I have recently seen a gentleman who told me that he consulted me in reference to his proposed marriage in 1890. He had had syphilis in 1888, had been treated for a year or more, and had been for nine months wholly free from symptoms and without treatment when he came to me. He assures me that I gave him full permission to marry, and as more than two years had elapsed his statement is, I have no doubt, correct. He married in October, 1890, two years and six months from the date of his chancre. On return from his honeymoon he had to consult his medical attendant on account of an abrasion on his glans. It was not, he believes, on the site of the former chancre. It was said to be nothing, and in the course of a week or two was well. His wife, however, about two months after marriage came out in an eruption which was pronounced to be syphilitic. She had conceived, but as she had complained of soreness, and as he had had an excoriation, it is more probable that she contracted primary disease than that she was infected by her fœtus. She was treated for syphilis, and got rid of all symptoms for a time. The child, a girl, born at eight months, also required treatment, but is now well.

Thus it is beyond doubt that in this instance a newly married wife contracted syphilis immediately after her marriage. It is also certain that the man she had married had suffered from prolonged constitutional syphilis, the beginning of which dated back two years and a half. The probabilities

seem to be that sexual intercourse abraded the glans and that the sore thus produced proved infective to his wife. We must, however, stop short of assuming that this is proved. There is the possibility that either he or she may have acquired syphilis from some other source just before or just after marriage. There is no known probability that such was the case, but it is yet a possibility. I have seen a case in which a young married lady of good family developed a sore on her genitals, as was supposed at first, from rupture of the hymen. Enlarged glands in the groin resulted, and after a few weeks a syphilitic eruption. Her husband had no syphilis, and had never had any, and the upshot of a most searching inquiry was that the sore had been contracted by unchastity just before marriage. It is obvious that in such a case, if the husband had admitted syphilis, no matter how many years ago, that the suspicion would have attached to him. We can never be sufficiently on the alert as to such possible sources of error in reference to sexual matters, nor must the position or apparently excellent character of our patients ever be allowed to mislead us.

No. XLVI.—*Supposed transmission of Syphilis by a father who married four years after his disease—Doubts as to the Diagnosis.*

The case of Mr. R—— is one of much interest in reference to possible errors in the history of hereditary syphilis. This gentleman married, with my permission, in 1878, having had syphilis four years previously, but appearing to be in perfect health. His family medical attendant, in a country town, knew all about his syphilis. Within a year of his marriage his wife was confined. Both he and his wife had remained apparently in sound health. The child at birth appeared healthy. Six weeks after its birth I had a letter from the family medical attendant, stating that the infant had, two weeks previously, that is at one month old, lost its health and become wasted. My informant added that he had found two rather deep ulcers—one on each side of the fauces; and that after attending it three or four days it had suddenly

struck him that the case might be one of congenital syphilis, that he had given one grain of calomel four times a day, under the influence of which the ulcers had entirely disappeared, and the child's health had been almost completely restored. Thus it will be seen that the child had no rash or snuffles, and that a fortnight's treatment with calomel had sufficed to quite cure it. It was impossible, however, to reject the evidence, which seemed to imply hereditary taint, although at the same time one could not but remember that deep ulcers in the fauces are amongst the very rarest of occurrences in that disease, and, further, that it is often not very easy to inspect the fauces of a young infant without error.

I heard no more of this family for fourteen years. At the end of this time Mr. R—— called on me in much distress because another child of his had died. Two children had been born since the one whose infancy is described in the above notes, and of these one, a girl, was living, and in excellent health, having never shown a single suspicious symptom. A third child, however, born about a year ago, had wasted away, and the family surgeon had suggested that his wasting was due to syphilis. On careful inquiry I could not discover that there had been any suspicious symptoms excepting the wasting. I was told, however, that the eldest boy, now aged 14, had got deformed teeth, which had been regarded as characteristic. Mr. R—— and his wife had both of them remained in excellent health. It is to be particularly noted that Mrs. R—— had never at any time displayed any suspicious symptom. I had never seen the eldest child, and it occurred to me now to ask if it could not be brought to me, that I might see for myself whether he displayed any indications of inherited taint. He was away at school, but his father at once acceded to my wish that he should be brought up for my inspection. This was done. I found that he had his teeth rather severely defective, but the conditions were those due to stomatitis and probably mercurial, and not characteristic of syphilis. His upper central incisors were undoubtedly "notched"; but the notches were broad and due to the breaking away of craggy edges, and not to an arrest of development of the middle denticle. He was a well-grown,

very healthy-looking lad; there was not the slightest peculiarity about the formation of his skull, nor anything in the least indicative of syphilis in his physiognomy. I examined his choroids and found no trace of disease.

It will be seen that there still remains for us, as a help in diagnosis, and a conclusive one, the possibility that this boy may yet show interstitial keratitis. If he should never do so, I may confess that I shall feel much inclined to doubt whether there has ever been syphilis in the family. It will be seen that the solution of the doubt is extremely important. If Mr. R——'s eldest boy really suffers from syphilis, then it would seem proved that a father, at the end of four years after his syphilis, and whilst himself remaining in perfect health, may be the father of a tainted child. It would prove also that the wife, who bore this child, may remain apparently in the most perfect health. Further, the facts would seem to imply, although not to prove, that in inheritance, under the conditions described, from one or both parents a tainted child might be born, destined to die of the disease, so long as sixteen years after the acquisition of the malady by the father. I am by no means prepared to deny the possibility of any of these occurrences, but they are all of them very improbable, and we ought to be very careful as to what evidence we admit in their support.

No. XLVII.—*Difficulties in the Diagnosis of Syphilis.*

One of the most difficult cases which I have ever had to determine whether a man had or had not had syphilis was that of Mr. P——. This gentleman, then aged 23, was brought to me by a medical friend in February, 1883; his limbs and trunk were covered with a dusky lichenous eruption, which had been out for one month. It was as like a syphile as possible, and Mr. P—— admitted exposure to risk on several occasions, but he had never had the slightest abrasion. Mercury had been prescribed before I saw him, and the rash was considered to be already fading. The most careful examination failed to discover anything like the remains of a chancre anywhere. He had no sore throat. I

expressed doubt as to the diagnosis, and advised the tentative disuse of specifics. This was done, and during the next fortnight the eruption faded away, with general desquamation. A year later Mr. P—— came to me, very nervous, about some falling of his hair, but he had no other symptoms of syphilis. He was liable, however, to some herpetic sores on his tongue. Ten years later he consulted me again, this time in reference to his marriage. No reminders of syphilis had occurred in the interval, and I of course told him that he might quite safely marry, although I could by no means feel sure that he had not had syphilis.

No. XLVIII.—*A Chancre which remained indurated for ten years.*

A surgeon, aged 31, consulted me about a sore, with a most extraordinary history. It was situated in the roll of the reflected prepuce, and was so hard that I took it for a recent Hunterian chancre. He assured me, however, that it had been present for ten years; it was as hard as cartilage. He admitted that it had definitely increased during the last six months. In support of his assertion that the sore was not of recent origin were the facts that he had no enlarged glands in the groins, nor any eruption or sore throat. According to his account he had never submitted himself to any systematic treatment. In the first instance the sore had been diagnosed as non-infecting; three years after its commencement he suffered from orchitis, which was painless, and which was diagnosed as syphilitic. It disappeared after very little treatment. Dr. K—— appeared to have absolutely neglected his symptoms throughout; but he did not admit that he had ever suffered from anything definite except the persistent chancre. He consulted me chiefly on account of a sore tongue. His tongue was ulcerated and showed filmy patches with much papillary overgrowth; I could not, however, feel sure that it was syphilitic. The chancre in this case was a long low roll of cartilaginous induration: it was congested but not ulcerated.

No. XLIX.—*Induration of a Chancre lasting, in spite of treatment, for two years.*

I have seen not a few cases in which indurations have persisted in the site of chancres for very long periods. The above is, however, an extreme instance of this curious phenomenon. Since writing out the case, another example, the facts respecting which are of considerable interest in more than one direction, has come under notice.

A gentleman, aged 27, was sent to me by Mr. J—— T——, of S——. The history was that he had contracted syphilis two years ago, and that in spite of much treatment the chancre had still persisted. I found a collared induration in the roll of the reflected prepuce. It was of considerable size, and as hard as cartilage. At its base was a superficial non-secreting ulcer. The patient assured me that this was his original chancre, and that, although it had varied in size and degree of hardness, it had never wholly disappeared since he first acquired it. He said that it had repeatedly healed, and that he had generally attributed the fresh ulceration to irritation during intercourse. He had abstained from intercourse entirely for nine months after the first chancre, but not so of late. During the last eighteen months he had been almost continually taking either mercury or iodide of potassium, and on several occasions had had his gums slightly sore. Whenever they were so, the mercury had been left off and the iodide substituted. The latter had always had the effect of depressing him very much.

The history as regards the early stages of this remarkable case, was that at first the sore was supposed to be "soft," but that it indurated after a month or two, and would not heal. No specific was used until it had been present nearly two months. The glands in the groin enlarged and became hard, but there was no threatening of suppuration. At no time was any definite eruption observed on the body, and although his throat was sore, his medical attendant did not consider it was characteristic. The glands in the groin subsided, and at the time that he consulted me there was nothing very definite. The patient was a man of dark complexion and

excellent health. He had lost flesh and strength considerably during the last two years, but this was probably to be attributed chiefly to the treatment, as he had taken a great deal of iodide of potassium, &c.

These cases are of great interest in reference to the pathology not only of syphilis but of other infective diseases. They have also a very important practical side. It is clearly impossible to say, in fact the probability is perhaps the other way, that chancres which have existed even for several years may not still retain some contagious elements. It would appear to be possible for these elements to remain living in the tissues in which they were first implanted long after they have died out from the system generally. By far the most important risk to be contemplated, when according to rule we permit marriage two years after syphilis, is the possibility that under the influence of renewed and repeated intercourse the original chancre may relapse. I believe that this risk is a very small one, but it is impossible to deny its reality. I have published several cases in which, under circumstances of apparent safety, chancres have returned. When they do so it is always, I think, in the site of the original sore, and this site is also almost invariably in the roll of the reflected prepuce. As regards these persisting indurations, it may be suspected that they always occur in cases in which the treatment has been inefficient, and not unfrequently in those for whom the iodide has been substituted for mercury. Clearly the measure to be carried out is a long continued or otherwise thoroughly efficient course of mercury.

No. L.—*Permanent cures of Tertiary Syphilis.*

I treated an officer in the army (Mr. A. H——) in 1880 for a most severe tertiary ulceration of the throat. Several cauterisations with nitric acid were required, but by their aid and local applications of iodoform, and without the use of iodides and mercury, it finally healed well. I saw him again in 1893, when he had the appearance of perfect health, and told me that during the thirteen years which had elapsed he had never ailed anything.

I also treated the brother of the above patient in 1887 for a very large ulcerated gumma on the front of one leg. It was ten years after his primary symptoms. His sores healed under mercury, iodides, and iodoform. In 1893, that is after six years, I heard that he had since the treatment had good health, but was now urgently ill with acute catarrhal pneumonia of four days' duration.

No. LI.—*Two attacks of Syphilis with an interval of nearly five years—Apparently excellent recovery from both.*

AGE.	DATE.	DETAILS.
28	1877	Had a chancre (pœnal), not much hardened.
29	1878	Complete secondary symptoms. Treated by mercury.
30	1879	Periostitis on one tibia. Cured by biniodide.
31	1880	Quite well.
32	1881	Quite well.
33	1882	A second chancre, well indurated and characteristic.
34	1883	An ulcerated throat and some pustules on scalp followed the chancre.
35	1884	A gumma on one leg, which ulcerated, and has left a deep scar.
36	1885	Quite well.
37	1886	,, ,,
38	1887	,, ,,
39	1888	,, ,,
40	1889	,, ,,
41	1890	,, ,,
42	1891	,, ,,
43	1892	In excellent health. For eight years past has taken neither mercury nor iodides.

I did not myself see this patient until 1892, when he consulted me solely on the question of marriage. The diagnosis of all the symptoms mentioned rests therefore with the patient himself and the surgical friends whom he consulted at the time. He was an intelligent and experienced surgeon. The case illustrates the occurrence of a second chancre, which, as regards induration, presented much more charateristic conditions than the first had done. It was followed by a characteristic sore throat, and that the eruption was not more plentiful may be plausibly explained by the circumstance that early treatment was adopted. The case offers also a good example of successful treatment on both occasions, although in each symptoms of the tertiary group occurred.

No. LII.—*A second hard chancre two years or more after a first—Both treated by Mercury—Some doubtful secondary symptoms after the second—Periosteal and cerebral symptoms two years after the second, with double optic Neuritis.*

AGE.	DATE.	DETAILS.
26	1886	Had a chancre, which Dr. H—— assured him was hard, and treated by a three months' course of mercury. It was long in disappearing.
27	1887	No secondary symptoms that he remembers appeared. No treatment.
28	1888	Quite free from symptoms. No treatment.
29	1889	Quite free from symptoms. No treatment.
30	1890	In the early part of year another chancre, which was again by the same surgeon diagnosed as hard, and treated by mercury. The sore did not last a month, but some eruption followed.
31	1891	He continued treatment by mercurial baths, iodides, &c., on account of some eruptions and periosteal pains.
32	1892	He came June 7th (for first time) to me with sore nose and pains in shins. Afterwards (in September) pain in occiput, drowsiness, giddiness, and double optic neuritis.

The diagnosis of the chancre in this case was by the same surgeon on both occasions. He is a well-experienced specialist, and he is reported to have expressed a very positive opinion respecting it. The sore on the first occasion lasted about two months ; in the second, only one.

No. LIII.—*Syphilis from inoculation without primary sore.*

I have seen several cases in medical men who have received slight injuries to their hands, and in whom constitutional phenomena of syphilis followed without the occurrence of any primary sore. In one of these, a little brown stain was all that was ever noticed as marking the site of the part which had been pricked. It was so insignificant that it would never have been noticed had not constitutional symptoms followed. I have quite recently seen another case, in which the absence of local symptoms was yet more absolute.

A medical man of middle age, who had never before had syphilis, attended a woman in her confinement who had on her vulva numerous condylomata. The perinæum being torn, he was under the necessity of using stitches, and it unfortunately happened that he pricked his hand. The prick was a quite definite one and drew blood, and knowing as he did that the woman had syphilis, he was from the first very anxious about himself. On the same day that the accident occurred he consulted his partner as to whether anything could be done to prevent infection. As there was no abrasion, it was decided to be useless to attempt any cauterisation. No local changes whatever occurred. The accident occurred on December 16th, and about the middle of February some spots were noticed for the first time on the trunk. I was consulted on March 7th, and at that time there was a tolerably plentiful papulo-scaly eruption on the chest, abdomen, and fronts of arms, about the nature of which I could not feel any doubt. The condition of the tonsils was suspicious, but not quite definite. The site of the prick in the hand could not be identified, and there was no swelling in the axilla. I was allowed to make a complete examination, and could find no trace of a chancre elsewhere.

No. LIV.—*Very severe Syphilis—Primary, secondary, and tertiary stages all within a year—A former attack possible.*

A gentlemen of forty, passing through London in his return to a colony, consulted me on account of a sore which he had been assured was "soft." He had contracted it on July 27th, and I saw him on August 22nd. The frænum had been destroyed by an ulcer which was now assuming induration. I told him that he undoubtedly had syphilis, and as usual prescribed mercury in the form of grey powder pills. I heard nothing more of him until nearly two years later, when his surgeon, being in London, was good enough to call to give me the sequel. It had proved a most severe attack. The sore had become phagedænic and destroyed a considerable portion of the glans, and there had followed a copious eruption of

rupia. No sooner was the rupia thought to be nearly well than ulceration occurred in his nose—periosteal gummata. Thus within a year of his contracting the disease, the vomer, the whole of the hard palate, and almost the whole alveolus on both sides of upper jaw had been lost by exfoliation. Under liberal treatment by specifics, &c., in various forms, the disease had at length been conquered, and the patient was in fair health and free from symptoms. He was, however, severely scarred, and had an enormous hole in his palate which exposed the sides of the nasal chambers.

Before we accept such a case as this as an instance of syphilis running into the stage of periosteal gummata with exfoliation, before the secondary symptoms had cleared and within a year of its acquisition, it is necessary to add the record of another fact. When he first consulted, me Mr. C—— told me that he had twelve years before had a sore which he was told was "soft," and from which nothing had followed. Thus it was quite possible that his recent attack was a second one. The fact that his second chancre ulcerated from the first, destroyed the frænum, and finally became phagedænic after it had assumed induration, favours this view. In most cases of phagedænic chancre there is, in my experience, the history of previous syphilis, or at any rate of a previous sore. The same remark applies to the occurrence of rupia and to all forms of ulcerating secondary eruption. It is not possible in this instance to say anything with certainty as to the influence of specific remedies. Did the phagedæna and rupia occur in consequence of the mercury given, or were they rather from want of larger quantities? In an early stage, when the disease threatened unusual severity, the grey powder pill was substituted by the protiodide of mercury, and it was whilst taking the latter that the disease became yet more aggravated. Although it resisted treatment for long, yet finally specifics conquered. Very large doses of iodide of potassium were given. There can be no doubt that the patient was susceptible to the poison of syphilis in a very peculiar manner. This was proved at every stage, and the question of most importance is whether this peculiar susceptibility came from the influence of a previous attack.

DISEASES OF THE NERVOUS SYSTEM.

No. XLV.—*On the Early Symptoms of Tabes.*

It is often exceedingly difficult to distinguish the flying pains of tabes from those of gout; not infrequently, I believe, the two diseases co-exist; and although the diagnosis of tabes from other symptoms may be certain, the pains may still be in part due to gout, and may be curable on that hypothesis. The case of Mr. M——, a man aged 30, whom I saw in January, 1893, illustrates these statements. I had treated Mr. M—— in January, 1890, for some tertiary symptoms of syphilis. They consisted solely of sores on the tongue, and it was then eight years since the primary disease. I cured his tongue by insisting on the removal of some teeth which were stopped with black amalgam, and on his giving up smoking. The acid nitrate of mercury was also applied. When Mr. M—— came to me three years later, his tongue had for long been quite well, and he had been quite free from all symptoms of his old complaint. He came because he had been suffering from pains in his thighs, and sometimes in his chest. He said that the pains were very peculiar, "as if the flesh were screwed up and then let go again;" they would come on at any time, and would sometimes make him stop suddenly when walking. Not unfrequently they would wake him in the night. They seldom lasted more than for a few minutes at a time. He said it was more than three or four years since the liability to them began, but that the frequency of attacks had much increased of late. As his father had suffered much from gout, he had until lately considered that they were of that nature. Latterly, however, their frequency and severity had been such that he had doubted this diagnosis. Another

peculiar symptom had been gradually developing, *pari passu* with his pains. He had become quite unable to get into a hot bath. If he did so, it produced not a sensation of scalding of the skin, but a deep aching of the limbs which was quite intolerable. In using a warm bath he was obliged always to get into it at a tepid heat, and then gradually turn on the hot water. In this way he could increase it up to 98° with comfort. I found that his pupils were very sluggish, the left, indeed, was almost motionless. Both were larger than usual, and the left was larger than the right. His accommodation was good; he had had no bladder-symptoms, and he could walk with perfect ease with his eyes shut. His knee-jump was poor in the left, but fairly good with the right.

I can have no doubt that the symptoms mentioned were the very slow beginnings of tabes; but as the patient thought that his pains were definitely influenced by his diet, I do not think it improbable that they were, in part, of a gouty nature; and I advised him to put himself under a careful regimen in the hope of their prevention.

Another case, which I may place by the side of the preceding, and to some extent in contrast with it, is that of Mr. M—— H——. This patient, a man of 41, had a family of nine healthy children. In early life, however, before his marriage, he had suffered from syphilis. He was apparently in good health, and was under my treatment only on account of a superficial rodent ulcer on his nose. One day after I had seen him on this ailment, he mentioned to me that he had of late been much troubled with nocturnal incontinence of urine. I passed a bougie, and found that he had no stricture; and it became, therefore, somewhat difficult to explain such a symptom in a man of his age. He threw some light on it, however, by reminding me that three years ago he had consulted me on account of pains in his lower limbs, and that I had prescribed anti-pyrine to be taken at bedtime. On referring to my notes, I found that I had written against his name on October 14, 1891, "Ataxic pains." The disease had made no great progress, and his

chief complaint was that he tired much more easily than formerly. Micturition, he said, was very feeble, and his sexual vigour was rapidly failing. His knee-jump was decidedly excessive.

The explanation of nocturnal incontinence in tabes may possibly be simply defective sensation in the neck of the bladder, thus allowing the patient to sleep through a call which would otherwise awake him. I found that this patient, in spite of his annoyance, was still in the habit of drinking a couple of glasses of whisky-and-water before he went to bed. I had, therefore, no difficulty in telling him how I thought he might be relieved.

No. XLVI.—*Cases illustrating Syphilitic Disease of the Nervous System.*

There are few cases more difficult for prognosis than those in which the nervous system suffers in syphilis, and I have thought that the three cases which are to follow (in tabular statement) are worthy of record in reference to this matter. In all, the history extends over a long series of years. The cases have no special connection with each other, beyond the fact that they were all examples of nerve disorder after syphilis.

In the first (No. 46), the chief feature of interest is the permanent and almost complete recovery after a very severe cerebral illness. The liability to epilepsy entirely ceased under treatment, and the patient, although he remained quite blind, regained his health and was able to marry.

The points in the second case (No. 47) are: first, that the patient had two definite attacks of syphilis, and, secondly, a very long duration of tabetic pains of considerable severity, but without other marked symptoms.

The third case (No. 48) is one in which ophthalmoplegia, which threatened in the fourth year of syphilis, was warded off by specific treatment, and did not occur till ten years later.

I have stated them all in the space-for-time method, which will, I believe, much facilitate the reader's appreciation of their facts.

No. XLVI.—*Permanent recovery from Meningeal Gumma.*

Syphilis. Epilepsy repeated and frequent, with severe headaches, in fourth year. Optic neuritis and rapid total blindness. Recovery under treatment. Disease in nose ten years later. Good health (with total blindness) thirteen years after the attack. Enormous doses of iodide.

AGE.	DATE.	DETAILS.
25	1870	Chancres on penis for first time (indurated).
26	1871 (1)	Secondary eruption all over his body. Treated imperfectly.
27	1872 (2)	Well, but with reminders.
28	1873 (3)	Epilepsy: frequent from August to March. Severe headaches and great loss of health, and confined to bed.
29	1874 (4)	He became totally blind. The epilepsy ceased soon after.
30	1875 (5)	No epilepsy. Improving.
31	1876 (6)	No epilepsy. Improving.
32	1877 (7)	Return of epilepsy; a single attack.
33	1878 (8)	Gaining ground.
34	1879 (9)	Gaining.
35	1880 (10)	In fairly good health.
36	1881 (11)	Married (no conceptions followed).
37	1882 (12)	In fair health, and accustomed to much brain work.
38	1884 (13)	In fair health.
39	1885 (14)	Anæmic; ulceration in nose. Septum perforated (a very small hole). In fair health.
40	1886 (15)	
41	1887 (16)	Seen by me for first time. Quite blind, but in good health. I advised no further treatment unless symptoms should occur.

He was treated for his headaches and epilepsy by mercury, &c., and got rid of them about the time that his sight failed. He was in bed prostrate with headache at the time that he lost his sight, but he never had any paralysis.

About six months after the sudden failure of sight he regained bare perception of light, but has not improved since. He still has perception of light, and just managed to count the windows in my room, mistaking a mirror for one.

He used to have "dead-ache" in his legs (shin-bones)—"excruciating pain"; kept him awake at nights. He had no lightning pains.

Divergence of right eye, but no paralysis of muscles. Pupils of normal size, No. 4. No knee-jump, but there are no other signs of tabes. He avers that his sexual power is good. Optic discs white and atrophied.

In 1885 he took two-drachm doses of iodide three times a day for six weeks continuously, for the disease in his nose. It suited well.

He seems well, and says that if he could see, he was never better in his life.

His fingers go to sleep easily, and become dead from any slight pressure. It is possible that his very large doses of iodide may have caused this liability.

COMMENTS.—*This case is of much interest in reference to the prognosis of cerebral syphilis. There can be little doubt that in the years* 1873-4 *the patient had a meningeal gumma which caused his terrible headaches, epilepsy, and optic neuritis. From this he wholly recovered, and has preserved good brain health for thirteen years. He has married since this illness, and although he may still possibly pass into locomotor ataxy, the cure of the gumma seems to be permanent.*

No. XLVII.—*Tabes after Syphilis.*

Tabetic pains four years after Syphilis. A second attack of Syphilis. Continued liability to tabetic pain, sometimes severe, for more than twenty years. Diagnosis of Tabes in twenty-fifth year. Repeated attacks of Diplopia. Impotence. Defective articulation, gait, and use of hands.

AGE.	DATE.	DETAILS.
22	1856 (1)	Syphilis complete.
23	1857 (2)	
24	1858 (3)	
25	1859 (4)	
26	1860 (5)	Lightning pains in legs and soles of feet.
27	1861 (6)	Went to China. A second attack of syphilis; no secondary symptoms.
28	1862 (7)	"Sciatica"; lightning pains. General debility.
29	1863 (8)	At home; still pain.
30	1864 (9)	At home.
31	1865 (10)	At home.
32	1866 (11)	At home.
33	1867 (12)	West Indies.
34	1868 (13)	West Indies.
35	1869 (14)	West Indies.
36	1870 (15)	West Indies.
37	1871 (16)	India.
38	1872 (17)	India; came home.
39	1873 (18)	At home.
40	1874 (19)	India.
41	1875 (20)	India.
		No special treatment. Suffering from the pains frequently, but no diagnosis.
42	1876 (21)	MARRIED. In good health, but liable to attacks of pain.
43	1877 (22)	India. In good health.
44	1878 (23)	India.
45	1879 (24)	Diplopia. Dr. H. J. diagnosed Ataxy for first time.
46	1880 (25)	
47	1881 (26)	At home. Got rid of his pains by blistering and iodides.
48	1882 (27)	At home and Ceylon.
49	1883 (28)	At home.
50	1884 (29)	At home.
		Ataxic symptoms slowly advancing. Failure of sexual power.
51	1885 (30)	Ceylon. Third attack of strabismus. Large doses of iodide.
52	1886 (31)	At home.
53	1887 (32)	Jamaica; could still walk about well; speech became thick.
54	1888 (33)	July; comes to me (only just home from Jamaica).

Pupils very small and quite motionless. He sees nearly $\frac{2}{20}$ with either alone; either alone is better than the two together. He reads No. 1 with his glasses.

No girdle pain, nor any gastric crises at any time; no throat pains. Has had three transitory attacks of diplopia and strabismus.

Bladder: no derangement of function. Bowels: habitually constipated.

He walks unsteadily. There has not been the slightest knee-jump for some years.

He sleeps well. He never had any seizure or fit.

He speaks very thickly, but very seldom fails to enunciate a word.

He does not look ill. He walks badly, and only by aid of a stick. Impotence, now complete, has been progressing for several years. He says that he cannot write easily.

For some years the pains have been absent until quite recently, when they have relapsed. The thickness of speech is a peculiar and exceptional feature in Ataxy, and may indicate the approach of general paralysis.

He thinks that iodide of potassium does not depress him. Has taken much. Blisters have, he thinks, relieved the pains.

One of the most interesting points in this case is the long continuance of the pains before the other symptoms of tabes declared themselves. He is an intelligent man, and states that for twenty-five years he has been liable to most characteristic and severe pains in his limbs.

No. XLVIII.—*Ophthalmoplegia after Syphilis.*

Unsymmetrical Ophthalmoplegia in fourth year of Syphilis. Absence of most of the symptoms of Tabes. Knee-jump excessive in fourteenth year. Permanent loss of accommodation in one eye.

AGE.	DATE.	DETAILS.
24	1875 (1)	Syphilis complete; mercury for some months.
25	1876 (2)	Well.
26	1877 (3)	Well. Lost his voice. Saw Dr. M. M., who treated for syphilis. No relapse.
27	1878 (4)	Drooping of right eyelid and double vision. Treated by specifics.
28	1879 (5)	In good health. In excellent nerve.
29	1880 (6)	Good health.
30	1881 (7)	Married in June. In good health.
31	1882 (8)	First child born. It lived, and is healthy.
32	1883 (9)	Good health.
33	1884 (10)	Second child born. It lived, and is healthy.
34	1885 (11)	Good health.
35	1886 (12)	Good health.
36	1887 (13)	In April had double vision. He consulted me in November.
37	1888 (14)	Ophthalmoplegia, &c. State described in notes below.

He looks well, but a little bloated. He lived freely in former days; he was very vigorous sexually.

"Go to sleep sort of pain" in feet. Never kept awake. He still rides and hunts, but not so well as he did. Very liable to stiffness after riding.

The right eye has a tendency to turn inwards and cause squint. Is this from the effort to accommodate?

Right eye-pupil large and motionless. Accommodation quite lost. Vision with +10 perfect.

Left eye-pupil almost motionless. Accommodation good.

He can walk firmly with his eyes shut.

His micturition is weak, and he is unable to finish.

It is probable that many of the eye-muscles are defective, but it is very difficult to test them. In looking upwards he sees a dazzling, which is a sort of double vision—thus he usually sees two moons. The only definite defect is in the external recti.

1888, Sept. 8.—He has never had stabbing pains, nor any material pain of any kind in legs. He is liable to pain in the toes at night much like gout.

His urine sometimes escapes at night. Micturition weak. He complains of pain at root of penis.

Knee-jump still excessive.

He has some sexual desire, but is very weak. Pulse soft and feeble.

Some neuralgic pains in right side of face.

No. XLIX.—*Hæmorrhagic Retinitis eighteen months after Syphilis.*

A case of some interest as an example of hæmorrhage into the retina came under my observation in the person of a gentleman named F. B. Y——, on November 27, 1892. He had suffered from syphilis in April, 1891—that is, about twenty months previously; and he had been taking medicines, chiefly iodides, almost ever since. The history as regards his eye was that in October of 1891 he had an attack of inflammation in the right eye, which lasted two weeks, and left the eye weak. In the following May, on waking one morning, he saw what he calls "veins" before him; but more recently this appearance had changed to a movable cloud. When he came to me he was quite free from specific symptoms. He could see perfectly with his left eye, but only $\frac{20}{50}$ with the right; with the latter he could see better when looking downwards. He described what he saw as looking like a dark blot of ink, which hovered about in the upper part of his field of vision, and would sometimes come down and then float up again. The ophthalmoscope revealed a very large area of the retina bloodstained. The film of blood was very thin, and although in parts it concealed the retinal vessels, in others they could be seen through it. The margins of the patch were very abrupt; the optic disc was bloodstained over the whole of its surface, and near to it was a dense thick blur of dark blood.

Mr. Y—— was taking the three iodides in combination at the time he came to me, although he had no symptoms of syphilis. There was, I believe, a history of gout in his family, but I could not obtain any facts indicating special tendency to hæmorrhage. He had not suffered from bleeding at the nose, nor had he had constipation. His age was about 26.

PLATE XCIII.

TUMOURS IN THE CAUDA EQUINA.

This engraving is copied from one that was published in the 'Transactions of the Provincial Association,' by the late Dr. Fisher, Down Professor of Physics at Cambridge. It represents a mass of tumours connected with the Cauda Equina, respecting the pathological nature of which I must be content by transcribing Dr. Fisher's own words :—

"The tumour or rather mass of tumours, on which a great number of vessels are spread, was surrounded on all sides by the roots of the nerves forming the Cauda Equina. The lower portion of this morbid growth had the form of a tubercle. It presented several traces of vascularity in the centre, and had a scirrhous appearance; I could not, however, make anything out satisfactorily with regard to its minute structure. The upper portions of the tumour were softer, and were involved in a fine glistening covering; sections of several portions of them show them to be composed of a grey, semi-transparent, jelly-like substance, infiltrated amidst reticulated tissue, and marked with sanguineous striæ, several of which appear like two vessels."

Dr. Fisher further adds that the dura mater and arachnoid appeared to be quite healthy, and that the cord itself was also sound. Some of the nerves appeared to pass through the tumours, but the greater portion of them could be easily detached. There can, I think, be little doubt, when we regard the case in the light of more recent experience, that the tumours were of the nature of fibromata. The case is of much interest in reference to one at least of those given by Mr. Robert Smith in his splendid monograph.

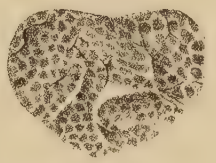
A reference may also be made to two preparations which are in the Institute of Pathological Anatomy at Vienna, and which I have briefly referred to at page 142, 'Archives,' Vol. iv. These two

specimens are regarded by Professor Kundart as examples of multiple gummata in the Cauda Equina. Excepting that the tumours were more fusiform, Professor Kundart's specimens much resembled the appearances shown in this lithograph.

To return now to the history of Dr. Fisher's case. The patient was a man aged 38. He died in May, 1840, having been nearly six months under Dr. Fisher's observation. It is recorded that he had been intemperate in his habits, but nothing is said as to syphilis. He believed that he had injured his back, in riding, about three years before his death, and from that time onwards he had suffered from pain in the loins, which was at first called rheumatism, but which gradually increased in severity and extended down the legs. One year before his death he was obliged to desist from his occupation as a tailor, and a few months later still he became bed-ridden. He was unable to lie down, but rested on his hands and knees. There was great numbness in the lower extremities, more especially in the left leg. He had difficulty in making water and some incontinence of urine. He was entirely free from symptoms in reference to his head, chest, and upper extremities; and notwithstanding the awkward position which he was compelled to take, he did some work as a tailor till within a week of his death.

There were large pressure-ulcers on his knees, which however gave him no pain.

It will be seen that the above history fits well with the slow growth of fibromata; and that there is nothing suggestive either of syphilis or of any infective form of malignant growth.



West, Newman, lith.

THERAPEUTICS AND DIET.

No. XXIX.—*Chrysophanic Acid in Lupus Erythematosus.*

I have, during the last two years, frequently employed weak ointments of chrysophanic acid for the treatment of lupus erythematosus, and have, on the whole, had much reason to be pleased with the results. Two especially satisfactory cases are at present under my observation. One of them, a shop girl, was so much disfigured by the patches on her face, for which she had already had much treatment, that she said that she should be obliged to give up her situation unless something more could be done. I gave her the chrysophanic acid ointment, five grains to the ounce, and instructed her to use it very sparingly. The first result was to make the patches much less conspicuous by making the whole face of a reddish-brown colour. When this subsided, which it did quickly, the patches were almost gone. She is still under treatment, but the patches are not now to be recognised, unless carefully looked for. The case was one of the most purely erythematous forms, and occurred on a fair skin. I have had several cases of absolute cure, nothing being left but very faint scars. Amongst the best of these I may mention that of an exceedingly handsome young lady, of a brilliant complexion and a somewhat phthisical aspect. In her the disease was only of a few months' duration and not severe. It consisted only of a few discs of scaly erythema, symmetrically placed on both cheeks. A six weeks' very sparing use of the ointment has so completely removed these patches that I had much difficulty in discovering their sites. On very careful inspection, however, I found

that there were some very slightly marked scars. Her mother told me that she observed them only at night, when her daughter chanced to be somewhat flushed, and that then they showed up as slightly white, being paler than the rest of the skin.

No. XXX. — *Note on the beneficial effects of a Mercurial Course.*

The effect of a vigorous mercurial course, although it would be very depressing at the time, is, I believe, beneficial to the health afterwards. An instance of this occurred in the case of Mr. J. H——. This gentleman inherited gout, and twenty years ago I had treated him for syphilis. He had married, and been perfectly well for almost the whole of this period till he began to suffer from rheumatic gout in his knees. He had considerable swelling in both, and some one having suggested that this was probably syphilitic, he was sent off to Aix-la-Chapelle. There he used the sulphur baths, and had also liberal inunction of mercury to full ptyalism. He found it, as he said, a very severe treatment, and was much pulled down, but the result was that his knees got quite well; and, during the next two years, he enjoyed much more vigorous health than he had ever known before. At the end of the two years he came to me suffering from rheumatic gout in one foot, but still in excellent health.

No. XXXI.—*On the Medicinal employment of Coffee.*

I have often been in the practice of prescribing coffee as a medicine in certain states of great debility. It appears to me to be a remedy quite unique in its usefulness in sustaining the nervous energy in certain cases. Apart from its general usefulness, I have found it of especial service after operations where anæsthetics had been used, and in states of exhaustion where alcohol had been pushed and a condition of semi-coma followed. In these latter cases I have sometimes prescribed it as an enema when the patient could not swallow, and with the best effects. Its value as an antidote to opium is of course

well known. Tea and coffee seem to me to be much alike in many respects, but I would give great preference to the latter as to its sustaining power. It would, I think, be a great advantage to our working classes, and a great help towards the further development of social sobriety, if coffee were to come into greatly increased use and if the ability to make it well could be acquired. As an example of the difference of effect of tea and coffee upon the nerves I may note, what I believe many sportsmen will confirm, that it is far better to drink coffee than tea when shooting. Tea, if taken strong or in any quantity, especially if the individual be not in very robust health, will induce a sort of nervousness which is very prejudicial to steady shooting. Under its influence you are apt to shoot too quickly, whereas coffee steadies the hand and gives quiet nerves. My object in the present note is, however, to illustrate the remarkable power of coffee as a restorative medicine.

In the case of an old man in whom colotomy was done in a very desperate stage, he being almost moribund, good rallying took place under injections of coffee and milk. During the first two or three days great use was made of coffee, and I believe that the recovery that resulted was largely to be credited to it. I have employed it in many similar, though less severe, cases. It is my almost invariable prescription for elderly people after an operation for which an anæsthetic has been given. One of the most remarkable facts, however, which I have ever witnessed, illustrating its powers, was the following. I was called late one evening to an elderly lady whom I had repeatedly seen previously on account of multiple sarcomatous growths in her bones. She had been in an almost dying state for more than a month, and at length it seemed that her end was come. I found her in a state of deep collapse, with pale face and dusky lips, and unable to speak or recognise any one. Her breathing was short and rapid. Her daughters were attempting to force brandy into her mouth by the spoon, but she could not swallow it, and I learnt that they had given a good deal of champagne and brandy during the afternoon. Her pulse, although very rapid, still beat well, and was not in keeping with her other symptoms of collapse. This made me

think that probably more alcohol had been given than was useful, and I resisted the importunity of the relatives that subcutaneous injections of ether should be made. Feeling sure that she was sinking, and expecting that all would be over in an hour or two, I wished to take my leave. The patient's daughters, however, in great distress, begged me to stay to the end. I waited about an hour, still refusing to administer more alcohol. At the end of that time the nose had become cold, and the face was bedewed with a clammy sweat. It was under these circumstances that, in consequence of the urgent solicitation to do something, I thought of trying a coffee enema. After the nurse had prepared it, she appealed to me as to whether she should give it, evidently thinking, as I did, that it was absurd to attempt anything in a patient so nearly dead. It was, however, administered, and with the surprising effect that within a quarter of an hour the patient opened her eyes and recognised those about her. In another half-hour she spoke to us, and colour began to return to her face. The coffee was repeated several times during the night, with the addition of some very small quantities of brandy. The result was that the patient recovered and lived on for three weeks afterwards.

In this instance I have no doubt that alcoholic stimulants, whilst they sustained the circulation, had acted injuriously on the nervous system, and that the patient, already extremely weak, had been pushed into a condition approaching that of intoxication. It is, I believe, very easy on the death-bed to over-use alcohol, although in the case which I have narrated, the disease being incurable and the suffering great, the prolongation of life for a few weeks was not a matter of real importance. There are, however, many others in which death may be close at hand where an expedient such as that which I have described may be the means of permanent restoration to health.

No. XXXII.—*Record of individual experience as to Diet in Gout.*

Mr. D——, a general in the United States Army, aged 51, gave me some interesting items of his personal experience re-

specting gout. He was a man of pale, earthy, almost leaden complexion, but still enjoyed fairly vigorous health, and had no conspicuous tophi. He had suffered, however, many and very severe attacks of gout in the great toe and other joints. He said that his grandfather, who was an Englishman and who was the first of the family to settle in the States, suffered from gout, and was during the last years of his life quite crippled. Neither his father nor any of his uncles suffered. He had himself lived freely all his life, and in spite of his gout he alleged that he still continued to eat and drink everything. I found, however, on detailed inquiries that there were limits to this assertion. He admitted that he dared not eat sweet fruits, more especially gooseberries, and that he believed that tomatoes had more than once given him gout. Burgundy also he was sure was very efficient in the same direction. Port was his favourite wine, and he still took it pretty freely and found no harm from it. Although he had at one time for two months been wheeled about in a bath-chair, he was now quite free from crippling, and he consulted me about an ailment unconnected with his gout.

No. XXXIII.—*Use of strong solutions of Tar in Eczema.*

I have on many occasions strongly advocated the use of tar-washes as being by far the best remedy for almost all forms of eczema. My favourite combination is a preparation of tar in the form of liquor carbonis with solution of acetate of lead. In most cases it seems to succeed best when very freely diluted; but I am accustomed to employ it according to its effect in very various strengths. A teaspoonful of each of the solutions named to a pint of warm water is a very common prescription; but it requires to be used, not only as a wash, but to be kept constantly applied on lint. In some cases a more convenient mode of application is a very much stronger preparation applied to the affected parts for only a few minutes at a time. The undiluted liquor carbonis alone is often very effectual for the relief of pruriginous affections. It stings at the moment of its application, but it relieves the

itching and does not cause smarting afterwards. A medical friend of mine, for whom some years ago I prescribed liquor carbonis with lead in a diluted solution, tells me that he has found it much more convenient and effectual in the stronger form. He uses equal parts of Wright's Liquor Carbonis and the Liq. Plumbi Diacetatis. Without adding any water, he takes a little of this solution in the palm of the hand and rubs it gently for a few minutes over the eczema patch. His experience is that it always kills the disease.

No. XXXIV.—*Ptyalism from the local use of the Ammonio-chloride of Mercury.*

It is necessary to bear in mind, when we prescribe ointments containing the ammonio-chloride of mercury, that the patient may possibly use them so freely as to produce salivation. The ammonio-chloride is usually regarded as an almost insoluble salt, and is often prescribed as if no hurt could come from it. In the vast majority of cases this is quite true, but we must not rely upon it too confidently. I have myself been in the habit of making the ammonio-chloride a constituent in a great number of the prescriptions which I have written for the treatment of eczema and other affections of the skin; its efficiency is very definite; but on at least three occasions I have been informed of its having produced rather severe salivation. In all cases it was in patients who were using the remedy very freely without remaining under supervision. I do not think that any inconvenience would be ever likely to result, if the patient were under the notice of a medical man. Ill consequences may, however, ensue when, in consequence of no suspicion being entertained, the ointment is still continued in use after the symptoms appear. Under these conditions two of my patients, one of whom had left England on a long voyage, were made very seriously ill. A knowledge of the fact is of considerable importance in two directions; first, in order that we may be on our guard, and either warn the patient beforehand as to what symptoms he may expect, or insist on his remaining under supervision during treatment; secondly, it is not without interest for us

to know that in using white precipitate ointments we are really, in a mild way, giving mercury, and may thus at the same time be benefiting the patient's health whilst we are thinking only of the cure for his local malady. I have long been in the habit of prescribing this ointment for syphilitic eruptions, in addition to giving a remedy by the mouth. It certainly assists in procuring the disappearance of the spots, and when the surface affected is considerable, it very probably helps also against the constitutional disease.

What has been said above, as regards the necessity for caution in the use of ammonio-chloride over large abraded surfaces, probably applies also to most of the other salts of mercury—calomel, the red oxide, yellow oxide and others. We do not, however, as a rule, employ these salts so freely as the white precipitate.

NOTES ON OPERATIVE SURGERY.

No. XVIII.—*Prostatectomy for Bladder Obstruction.*

The treatment of prostatic retention of urine, by means of operation, has, I think, received a very important simplification. As practised by the late Mr. McGhie and his colleagues at Leeds, to whom so much credit is due for taking the initiative, it was a very formidable procedure. It consisted, as then practised, in the removal, not only of what used to be known as the middle lobe, now re-named the vesical lobe, but of a considerable portion of the lateral lobes as well. The more recent proposal, and the one advocated by Mr. Buckstone Brown in his paper a few weeks ago at the Medical Society, recommends that the lateral lobes should be left untouched. This seems to be a very practical and common-sense proposal, for it is the projecting and valve-like vesical lobe which alone constitutes the impediment. The removal of this part only may be accomplished with comparative ease, for it is isolated and has a comparatively narrow base. It is easily accessible after opening the bladder above the pubes. Although I do not doubt that the supra-pubic opening affords the best means of reaching it, yet it will be well to remember that in former days when lithotomy was in vogue, it was not infrequently removed from the perinæum during the performance of that operation. Observations are not wholly wanting as to the benefit that accrued to patients who permanently recovered from their prostatic troubles after this occurrence. The cases to which I refer were, in the main, instances of unintentional removal of the lobe in question during the extraction of the stone. I have seen this done by several operators, and I especially well remember cases in which it occurred to Mr. Syme and Sir William Ferguson. I have had at least

three myself. Concerning one of these I am able to carry the narrative through a period of several years after the operation, and it may be worth while to record the facts.

About four years ago I was consulted by a gentleman who was extremely ill from cystitis, and who had been troubled for some time by incomplete prostatic retention. He had been under the care of a specialist up to the time of my seeing him, and had, after repeated soundings, been assured that there was no stone, and that what he had to do was to patiently continue the use of the prostatic catheter. As his sufferings were extreme and he was obviously not likely to live long unless relieved, I advised that a cystotomy should be done and the bladder explored. As the use of the sound gave him great pain, and as it had been recently employed in highly skilled hands, I did not resort to it until he was on the operation table under an anæsthetic. I then opened the bladder in the usual way by the lateral incision, and having forced my finger through a long prostate, I had the pleasure of finding a stone of very considerable size, which had been concealed behind a projecting third lobe. The stone was, without much difficulty, seized; but the extraction brought away in front of it a portion of prostate as large as a half walnut. Having ascertained that the bladder did not contain any other stone, I next proceeded to deal with the torn prostate; and partly by forceps, partly by the finger, took away portions altogether at least as large as that at first extracted. The passage into the bladder was now quite clear, and the operation was concluded by the insertion of a large india-rubber tube for the purpose of drainage. The patient, although a feeble man of 65, made an excellent recovery. He has never needed to use the catheter since. All traces of cystitis have vanished, and he can now both hold and void his urine in a perfectly natural manner. It is more than four years since the operation was done, and I have seen him quite recently.

The result in the above case affords much encouragement in reference to the performance of the modern operation, for nothing except the vesical lobe was taken away.

No. XIX.—*Ligature of the Brachial Artery for Wound.*

I had an opportunity of examining the condition of an arm after obliteration of the brachial artery, in the person of C—— M——. This gentleman, aged 29, had been injured whilst out pig-sticking, by the point of a spear which entered the inner side of his right upper arm. The profuse hæmorrhage was arrested at the time by bandaging, but an aneurism formed, and it became necessary to lay it open and tie the brachial. The operation was performed in India. In the end he made a good recovery.

When I saw this patient about eight months after his operation, everything had for long been quite sound. There was, however, no pulse to be recognised at the wrist, and the hand looked somewhat dusky, and felt quite cold. There was no evidence of any injury to any nerve, and C—— M—— said that he had regained almost complete use of it.

No. XX.—*Results of Operations for Un-united Fracture of Humerus.*

Some years ago I was consulted by a gentleman who had an un-united fracture in the middle of his right humerus. By the assistance of a leather case he could use his arm very well, and I advised him, as I have done several others in like condition, to be content with it as it was, and not to submit to any operation. This he decided to do; but after several years, coming under the care of a more zealous operator, he was persuaded to have the bone wired. This was done, and successfully, for the bone is now united, and the operation-wound soundly healed. He is not, however, by any means exultant at the result, for although about a year has elapsed, the arm is not so useful as it was before. He had a long and troublesome illness after the operation: abscesses burrowed, and required to be opened below the elbow, and many small portions of bone were exfoliated. The operation altogether kept him many months from business, and, he thinks, injured his health. In reviewing

the case, I am inclined to think that my advice was good. During the last ten or fifteen years, I have had under observation three or four examples of un-united fracture in the middle of the humerus. All of them were in gentlemen in robust health, and pursuing active occupations, and to all I gave the same advice, to be content with the support of a leather splint strapped round the upper arm. In all the use of the member, aided by this appliance, was tolerably good. I believe that they all, at one time or other, obtained the advice of other surgeons, but, with the exception of the one whose case I have just recorded, I believe that none of them received opinions sufficiently favourable to operation to induce them to submit to it. One of them was a sportsman, and could manage his gun very fairly in the field. One of them consulted a very distinguished surgeon, to whom he was introduced by a mutual relative. He received, as he told me afterwards, this opinion, "If you come to me as a friend, I say 'let it alone': but if I am to speak as a surgeon only, the right thing is to operate." This expression very well represents my own feeling on the subject. If I had an old-standing un-united fracture of the humerus, and were able to manage the arm pretty well with the aid of a splint, I would not—knowing what I do of the uncertain and frequently imperfect results of operations—seek the performance of one.

No. XXI.—*Successful Amputation in a case of very painful stump with contraction.*

A case which I reported briefly two years ago was that of a man who had sustained an injury to his thumb, and in whom the thumb had afterwards become painful and been amputated. The pain persisted in the stump, and the whole of his fingers became contracted into his palm. The hand was quite useless, and was, besides, the cause of great suffering. The man attended for demonstration at one of my post-graduate lectures, and I also had a photograph taken. It became a matter of great importance to estimate the probable results of another amputation. The removal of the thumb, which at the time was supposed a radical

measure, had quite failed to arrest the neuralgia. Indeed, the conditions had become much aggravated since the operation. The man had been a patient both at the London Hospital and at the Hospital for the Diseases of the Nervous System, in Queen's Square, and neither internal remedies nor the local use of anodynes had effected anything. Under these conditions, although well aware that many similar cases had ended in disappointment, I yet felt justified in recommending the man to have an amputation done through the forearm. The operation was performed at his home in Barnet, by my friend Dr. Thyne. This was more than a year ago, so that I am now in a position to report as to what may be fairly deemed as the result of the case. Dr. Thyne sent the patient up a few weeks ago for my inspection. The man is now in excellent health, and has a very good stump. He has been quite free from pain ever since the operation, and is able to follow his occupation without inconvenience. We may therefore consider that the amputation has been a complete success. His only complaint is that he feels the cold in his stump. It is, of course, within possibility that the neuralgic condition may yet develop in it, but the period of trial having been considerable, we may be hopeful on this point.

No. XXII.—*Excision of the Tongue for Cancer—Cases illustrating very rapid implication of the lymphatic glands.*

I operated on Mr. R——'s tongue at Brighton, in consultation with Mr. B—— of that place. The cancerous ulcer was very small, and had been considered, before I saw him, to be ill-marked. I felt no doubt about the diagnosis, and the microscope confirmed it. The operation consisted in the removal by the ecraseur of the right half of the tongue. The ulcer was on the right side, a little behind the middle. About six months after the operation I was asked to see Mr. R—— at Blackheath, and was much disappointed to find a large glandular mass under his sterno-cleido. He had also another enlarged gland under the jaw. This latter could easily

have been removed, but the mass in the neck was low down and involved many glands; it also passed under the cover of the muscle behind the clavicle. Its position was such that it was quite hopeless to think of removing it. I never in any other tongue case saw a gland mass in precisely this position, nor ever knew so many glands to be enlarged at once, and so quickly. The glands under the upper third of the muscle, which are more usually involved, were not implicated. It is these latter which are more usually attacked.

Within a few days of my seeing Mr. R——, I saw also another patient on whom I had operated about the same time and under very similar conditions. Mr. B—— had been sent to me from Dublin, and I removed from his tongue just such a piece as was taken from Mr. R——. In each instance, those who had seen the case previously thought that the disease was not cancer, and it was on the smallest possible scale. Mr. B—— came to me about six months after the operation, with a hard enlarged gland, quite movable, just under the angle of the jaw. I advised its immediate removal, and he returned to Dublin for that object. We may note that in both these cases the tongue itself remained perfectly sound after the operation. The responsibility of the return in the glands in such cases clearly rests with those who fail to take alarm early enough. Had the rule been adopted to excise freely everything that looks doubtful, I have no doubt that both these patients might have remained without any recurrence. One of them was the father of a large young family, and his life was in other respects of especial value. Both of them were just under fifty years of age.

No. XXIII.—*Distal Ligatures of Arteries for Thoracic Aneurism.*

Dr. Potter was good enough to show me, during a visit to the Kensington Infirmary, a patient in whom distant ligature of arteries for a thoracic aneurism had been performed some months previously. It was on January 6, 1893, that I examined the woman, and the operations had been done

in one of our London hospitals, in May and July of the preceding year. In the first instance the carotid and subclavian had been tied, and on the second occasion the axillary. When I saw the woman no pulse whatever could be detected at her wrist; a visible aneurismal swelling projected through the upper part of the sternum, or, apparently, through the sterno-clavicular articulation. It pulsated very freely, and the skin was beginning to thin, but there was no danger of immediate rupture. I asked the woman whether it was her impression that any of her symptoms had been relieved by the operation, to which she replied in the negative. She did not appear, however, to suffer much from her disease, and said that if she could lie quite still in one position she had but little pain. The tumour could be felt pulsating quite freely and rather forcibly above the clavicle. I should conjecture in this case that the vessel involved is the arch of the aorta rather than the innominata.

We have in the London Hospital a very valuable specimen showing complete cure by lamination of an aneurism of the innominata. I published a description of this specimen in some Museum Notes in the *British Medical Journal* for 1870. In that case the cure was brought about by rest and repeated venesection.

MISCELLANEOUS.

No. XCIII.—*Some general statements as to the Laws of Pathological partnerships.*

Fundamental in all pathological partnerships, we have the intrinsic vital endowments of the body affected.

The endowments just referred to are of various kinds, and affect different tissues. They may be general or only local.

These inherited endowments may concern anatomical and physiological peculiarities only, or they may be the results of disease in predecessors, and thus of a definitely pathological character.

These intrinsic endowments receive modifications by the age of the individual, and may reveal themselves in very different ways in infancy, in youth, in adult age, and in senility. Age must therefore very often be reckoned an important partner in disease.

The sexual system, for the most part in abeyance in youth, very active in adult life, but in very different degrees in different individuals, and again in senility for the most part in abeyance, must in very many diseases be counted as active partner.

Some partnerships may consist solely of an inherited peculiarity with some external or postnatal influence, which has been brought to bear upon it.

In some cases several inherited peculiarities distinct in their nature may combine together to evolve a mixed form of disease.

To the mixture of hereditary peculiarities pre-supposed in the preceding sentence, there may be added some external influence or parasitic infection, and thus a still more complex result may be produced.

In some cases the partnership may be simply that of a zymotic parasite with the natural forces of a healthy body.

In others, the combination may be between a zymotic parasite and special inherited peculiarities, and these latter may vary almost infinitely in character.

The term hæmorrhagic variola does not designate any peculiarity in the variolous poison, but rather the results of the influence of that poison upon tissues peculiar in their endowments in reference to a tendency to bleed.

No. XCIV.—*Displacement of the Patella after Arthritis without Anchylosis.*

A man aged 22, very tall and lanky, was the subject of a very peculiar condition in his left knee-joint. By a complete dislocation of the patella on to the outer side of the external condyle, the whole of the front of the articulation was left exposed. He could flex and extend the knee quite freely, and when flexed, the condyles and the trochlea projected under the skin. Although the patella was freely movable, it could not be replaced. The tibia was straight under the femur when he stood up, but with a certain amount of rotation outwards. The whole joint was loose, and the tibia could be moved laterally, and rotated much more than was natural. The quadriceps was wasted, and he was quite unable to lift the limb from the bed when it was extended. There was no inflammation about the joint, nor any swelling of soft parts, nor alteration in the shape of the bones. The man attributed the condition to an attack of gastric fever when he was an infant a few months old. In confirmation of this suggestion there were the scars of three abscesses, above and below the joint. A very unusual feature in the case was that the joint had not been in any way stiffened.

No. XCV.—*Recovery after Fracture of Base of Skull in a boy.*

A gentleman who consulted me in 1886 on account of defective refraction, and in whom I found that one facial nerve was

partially paralysed, gave me an interesting history of recovery from an injury in which no doubt the base of the skull was fractured. His head had been crushed in a railway accident, and he had afterwards been three months in bed for an illness from which he was not at all expected to recover. It had left him permanently and absolutely deaf in the left ear, with considerable weakness of all the muscles supplied by the left facial nerve, and partial paralysis of the left sixth nerve. The optic disc in the left eye was also a little hazy, suggestive of bygone neuritis. The accident occurred when he was thirteen years of age, five years before I saw him, and was attended, I believe, by free hæmorrhage from nose and ear.

No. XCVI.—*A Case of Blanched Eyelashes.*

The following narrative of an example of local blanching of the eyelashes in association with neurosis has been supplied to me by my friend Mr. Debenham, of the Commercial Road :—

"A very neurotic woman, æt. 29, fair, with reddish auburn hair, was brought to me with hysteria, bordering very closely upon insanity. Her appearance was striking, owing to the lashes on the *inner* half of the upper lid of the right eye being *quite white*—strikingly so. The whiteness began in one lash only *in the centre*, and from that spread inwards to the nose. This occurred ten years ago on a voyage from Australia. There are no grey hairs in the head, but latterly some have shown in the inner quarter of the right eyebrow. She has had no blow or injury, or inflammation about the eye; no illness, and no neuralgia or headache; but there is a mark of a leech-bite close to the outer canthus of the right eye, which she thinks was put on after a severe attack of measles, which she believes caused her at that time some temporary blindness (at the age of 5). Her health has been always good. Her mother died of phthisis two years after giving birth to her."

I have seen several cases of local bleaching of the eyelashes, more or less similar to the one recorded above. Mr. Waren Tay has shown me at least one such case. I possess a good

portrait illustrating this condition in a man who had suffered from a very peculiar form of destructive iritis. He had lost both eyes, and in both upper eyelids, placed quite symmetrically, there were tufts of white eyelashes. His eyebrows and the rest of his eyelashes remained of their natural brown tint. There can be little or no doubt that these changes are brought about from lesions of the nervous system, and in that relation they are of great interest.

No. XCVII.—*Ventral Hernia in an Infant.*

A very unusual form of hernia in an infant was brought to me in the winter of 1892; the infant was in good health and otherwise well formed: it was six months old. The hernial protrusion was as large as the child's fist, and contained intestine, which was easily returned, but which was extruded again immediately the pressure was removed, the aperture being large. It came directly through the abdominal wall on the right side, a little above, and internal to, the anterior superior spine of the ilium. It appeared to be external to the border of the rectus. I do not know of any anatomical explanation of the occurrence of a congenital hernia in this position, and I never saw one there before.

No. XCVII.—*Extreme Obesity in a Woman.*

I saw in the Infirmary at Kensington, under Dr. Potter's care, a remarkable example of obesity in a woman. She was only just able to walk about, and presented the closest resemblance to portraits of Daniel Lambert that I have ever seen. The accumulation of fat was especially great in the abdominal wall and the back and thighs. Her face did not show anything peculiar. She told me that the tendency to fatten was in her family, that her mother was very stout, and that she had a sister only a little less stout than herself. As a girl she was thick-set and rather stout, but not unusually so. At the time of her marriage she was not, she thought, at all particularly stout. She had borne a very large family of children, but, with the exception of the first two, had not been able to nurse any of them. She considered that the tendency

to put on fat had been especially great soon after her confinements. She had never taken much malt liquor, but had been especially fond of farinaceous articles of food, potatoes in particular. She was a cheerful, intelligent woman, aged about 45. Her obesity had disabled her from all domestic occupations, and obliged her to leave her family in the care of others and come into the workhouse.

No. XCVIII. — *Long recognised Enlargement of Spleen with Leuco-cythemia.*

I saw in the Kensington Infirmary, under Dr. Potter's care, an old woman who had been for many years the subject of enlarged spleen. She was about 63 years old, and had been born in Aylesbury, but had lived the greater part of her life in London. She was not aware that she had ever been exposed to the risk of palludism; she considered herself in good health, if it were not for the tumour, but she was extremely pale, her ocular conjunctivæ being absolutely white. Dr. Potter told me that the proportion of white corpuscles in her blood was definitely increased. The spleen could be felt, or almost seen, passing down from under the ribs to the iliac crest. It was extremely hard, and much more nodulated than is usual with the ague-cake. She told us that the presence of the enlarged spleen had been recognised by various medical men during at least six years.

No. XCIX. — *Persisting Acro-dermatitis allied to Chilblains.*

A curious form of acrodermatitis was shown to me in the person of a young lady, Miss W——, aged 27; she was in good health, and had a fairly vigorous circulation, and never suffered from cold hands or feet. In March, 1885, she had, after an attack of diphtheria, some little red spots on the tips of her fingers, for which she was for some time under the care of Dr. Bowles, of Folkestone. When she got rid of them she remained free until October, 1892. At this date her fingers became swollen and tender, but there was no itching like

that of chilblains, and there was no affection of her feet. The condition lasted more or less during the next three months, and up to the date of my consultation, January 18th. On this occasion I found the fingers generally red and a little swollen, but I was told that they varied very much, and were at times much more so. There was nothing that could be identified as a chilblain. I have little doubt, however, that the disease, although peculiar, should be recognised as belonging to the chilblain group.

No. C.—*Selected Paragraphs from a Commonplace-Book.*

It may be suspected that almost all that we name inflammation, more especially in its chronic forms, is, on the part of the organism, an obscure effort of growth.

We often, in describing what we suppose to be the features of a disease, describe really the peculiarities of the individual.

Chronic rheumatic arthritis often takes its local habitation from an accident, whilst its name is from the diathesis.

A remarkable example of symmetry is afforded in the moulting of birds. The large wing-feathers are always shed in pairs, the corresponding ones in the two wings falling out within a day or two of each other. This of course tends to keep the wings of equal power in flight. The symmetry in turn is, however, approached more or less closely by the other feathers.

Eruptions which come suddenly, go away of themselves, and often recur, are either herpetic or catarrhal, or it may be both.

Do not name symptoms as if they were diseases.

Speak very cautiously of species in disease, and avoid altogether such expressions as *sui generis*.

Seek for causes rather than for names.

We must analyse, and seek to interpret partnerships in disease.

"Species is merely an abstraction of the human intellect, not a real boundary set by nature."

The recollection of this is yet more important in the investigation of disease than it is in zoology.

No. CI.—*Recurring Ophthalmitis with Opacities in the Vitreous—Mabey's Malady.*

Under the name of "Mabey's Disease" I have described certain very peculiar cases in which, in young persons, recurring attacks of iritis occur, attended by the formation of opacities in the vitreous, and resulting very frequently in entire loss of the eye. The disease appears to be definitely in association with the inheritance of gout, and the affection of the eye is usually accompanied by chronic disorganisation of the last joints of the fingers—acro-arthritis. This condition of the fingers ought, indeed, always to accompany an ophthalmitis in order to complete the picture of Mabey's malady.

I ought to add that liability to chilblains, feeble circulation, and tendency to tuberculosis, often enter into the partnership causation of this disease. The affection of the eye is, however, obviously its most conspicuous and important feature. In the following case, as yet, one eye only has suffered, and there is no disorganisation of the digital joints. There is, however, a known history of gout.

Miss D—— is a very pretty girl, of fair skin and blooming complexion, aged 21. One of her brothers is threatened with phthisis, her father was always very delicate, and she herself has never been robust although not definitely ill. She has for some years used glasses for hypertropia, and with them could see well with both eyes. About eighteen months ago her eyes began to suffer from attacks of irritability, and would ache and appear bloodshot. The condition often caused her for a few days to desist from reading for pleasure, but was never sufficiently severe to make her give up her duties as a

governess. Her right eye suffered most, and about a year ago she found that its sight was failing, and began to notice moving films in front of it.

It was with the above history that Miss D—— was sent to me on January 18, 1893. There was no redness of either eye when I saw her. She could with her glasses see perfectly with the left eye, but with the right only $\frac{2}{200}$, and barely that. The cause of her defect was easily discovered by the ophthalmoscope, for the vitreous was full of large floating films. The retina and disc could be seen, but in a very hazy manner. There were no iritic adhesions nor any pigment spots on the lens, but some very delicate striæ were observed in the periphery of the latter.

On my making inquiries as to arthritic affections, Miss D—— told me that she often suffered from pain and slight swelling in the joints of her fingers, both in the terminal ones and the next to them. No permanent changes had, however, been produced. She occasionally had rheumatic achings in her shoulders, &c., but she had never suffered from any severe form of rheumatism. I already knew more of her family history than she did, for it so happened that I had personally known her grandfather. She entirely denied any history of gout, but I knew that he used to suffer from it, and this her mother (his daughter) confirmed. Miss D—— had herself always abstained from stimulants, and there was not the slightest reason to suspect any acquired gout or tendency to lithiasis in her.

No. CII.—*Molluscum Contagiosum from use of the Turkish Bath.*

It is many years ago since I was struck by the fact that men who are in the habit of using the Turkish bath sometimes become the subjects of molluscum contagiosum on the trunk. At different times I have published several cases. In one instance my doing so gave great offence to the proprietor of the bath, and a correspondence ensued in which it was strongly denied by him that such cases were ever noticed among his clients. A few weeks ago, however, a gentleman

consulted me about some symptoms which induced me to request him to undress, and I then found that he had scattered over his chest and back a number of the little buttons of molluscum contagiosum. On my drawing his attention to them, he said, "Oh! those are nothing; they are merely due to a Turkish bath." I asked him who had told him so; and he replied that the attendant at the bath had said that he frequently saw them.

No. CIII.—*Senile Freckles occurring on the right side.*

I may add another fact as to senile freckles in the case of an old lady named H——. She has now, at the age of 71, extremely dark pigment-stains on her right lower eyelid. There is also a continuous crescentic patch curving up the right side of her nose round the inner canthus, exactly in the position where the xanthelasma patch so often occurs. There is, however, not the slightest trace of xanthelasma. It is deep-brown staining of the skin, and nothing more. According to what appears to me to be the rule, it must be noted that it is on the right side, the reverse of what usually occurs in xanthelasma.

Mrs. H—— has enjoyed good health through life, and has never suffered from liver disorder. There is a slight appearance of staining on the left, but not approaching that on the right.

No. CIV.—*On Simulations of the Ivory Patch of Morphœa.*

The conditions which constitute what is called the "ivory patch" in morphœa are usually definite and unmistakable. The expression is very appropriate, for the patch does look exceedingly like discoloured ivory. Sometimes it is of a dead white, at others bluish, but more commonly of a yellowish tint. Its margin always thins off gradually into the surrounding skin, and it is always thickest in its middle. I have met with but a very few cases in which I have had difficulty in deciding whether any given patch was an ivory

patch or not, and due attention to the points alluded to have usually been sufficient to decide them. Certain very white and slightly thickened scars offer the conditions which most usually present difficulty. The true "ivory patch" has nothing in common with a scar, and when it disappears leaves no scar behind it. It is probably due to a temporary occlusion of the vessels of the part, and to effusion into the perivascular spaces. It never shows any tendency, after once being well developed, to spread at its edges. I have often taken occasion to insist on this as a very important characteristic, and as proving that the process which attends it is in no degree infective. Several writers have asserted that there are exceptions to this, but the disaccordance of opinion results, I feel sure, from not having waited to allow the full development of the patch. The stage of development lasts one or two months, and after that is well past there is, according to my experience, never any aggressive spreading. It is quite possible that some of the cases which have been described as showing a tendency to spread on the part of the ivory patch, may have been examples of the simulations which I am about to describe, rather than the true ivory patch of morphœa.

I have at present under care a lady, the subject of lupus erythematosus, whose cheeks well illustrate the condition to which I have referred. Every time I see her, the thought occurs to me "those must be morphœa patches;" and I am obliged to look at them again and again to convince myself that they are not so. She is a florid lady of very fair complexion. In the middle of each cheek she has a patch somewhat larger than a shilling, exactly like a piece of inlaid ivory. The patches are smooth, glistening, and slightly yellow. They are really scars, for they have followed the cauterisation which I made more than a year ago. The lupus process has ceased to spread, and may in a certain sense be considered cured, but there is still some tendency to the formation of little discs on other parts of the face. In two or three other cases in which lupus erythematosus has been cured by cauterisation with acid nitrate of mercury the scars are smooth and glistening, and might easily be

mistaken for those of morphœa. The most remarkable instance of this deceptive similarity which I have seen has occurred in a young woman who was sent to me by my friend Dr. P. S. Abraham. Although in her case differences of opinion have been expressed, I feel confident that the disease is really lupus erythematosus and not morphœa. As in the first case I spoke of, the conditions are symmetrical, and the middle of the cheek is the part affected. Exactly in the centre of each "flush-patch" of the cheek there is a round shilling-sized area like ivory. The reasons for believing that these patches really result from lupus erythematosus, and not from morphœa, are the following. Their margins are distinctly erythematous and slightly swollen, and there are some little red discs close to them (satellites), which she says well represent the early stage of the patches on her cheeks. There is also some roughness over the whole of the bridge of the nose, and the patient states that she had formerly patches in that position. The state of the little discs mentioned is characteristic of that of lupus erythematosus, and not at all that of morphœa. It is only, therefore, in the stage of retrogression, and scar, that the latter is simulated. There is, however, a further item of evidence. The patient suffers very much from chilblains. Her fingers are covered with erythematous papules, some of which present depressions in the middle. This is a valuable item of corroborative evidence.

No. CV.—*Note on the difficulty of effecting complete removal of the Nails.*

In a paper read last November before the Royal Society by Dr. F. A. Dixey, attention is asked to the fact that the corium underlying the epithelium of the nail is continuous with the periosteum surrounding the distal extremity of the ungual phalanx, and that the two structures are histologically very similar to one another.

This anatomical fact may perhaps account for the extreme difficulty which exists, especially in children, in completely extirpating a nail. I had recently occasion to attempt this

in the case of a girl in whom I was told that two operations had failed. Although, as the operator told me, he had taken the utmost pains to secure removal of the entire nail, fragments of a new one had been reproduced, and as they had again inflamed and become painful, I was asked to attempt it the third time, on account of the disappointment which had been encountered. It may be understood that under such circumstances I took especial care to excise the whole. The child was under an anæsthetic, and the circulation being controlled by an indiarubber band the dissection was not obscured by blood. I removed, as I thought, everything down to the bone, and in parts even took portions of periosteum. At the sides I left nothing that could be suspected to be nail-bed. In spite, however, of all my precautions the wound was no sooner healed than the scar, at several different points, began to form nail. It was not very much, but enough to be quite definite and to cause some irritation.

No. CVI.—*Indian Ringworm on thighs—Subsequently Pruriginous Dermatitis—Temporary cure—Relapse and slow development, during ten years, of incurable and almost universal Dermatitis—Finally, after fifteen years, the condition of Mycosis Fungoides—Note on the importance and peculiarity of the Gland disease attending that malady.*

A man named P—— came under my observation in June, 1886, whose case has subsequently assumed much interest as an example of what is now known as Granuloma fungoides. His condition when I saw him six years ago was that of general dermatitis of a mixed character, which had been intensely pruriginous and terribly scratched. He admitted that he sometimes spent half the night in scratching. He had spent a year in continuous treatment at Harrogate just before I saw him, and without benefit. Previous to that he had given up a good situation in Ceylon on account of the

incurability of his disease. He was thirty years of age, and married.

Mr. P——'s account of his malady was that he had in the first instance suffered from Indian ringworm, which was treated by Goa powder. This was followed by much irritation, and thirteen or fourteen years before I saw him patches developed behind one knee and on the tips of the elbows. A year later his palms were affected. In 1875 he left Ceylon, and, returning to England, put himself under the care of a specialist, who cured him completely for a time. His legs were at that time severely affected and much swollen. He had had much trouble from soreness under the edges of his nails. Early in the case the glands below the groins had become enlarged.

My notes describe Mr. P—— as suffering from an eczematous form of lichen, with extensive changes caused by scratching. The skin of his lower extremities was thickened, and there were long, narrow ridges, almost keloid in character. His face was not much affected and never had been, otherwise the dermatitis was nearly universal. On the hands it was definitely eczematous. He complained of a distressing sensation, as if coated with clay which had dried on him. His health was still good, and he said that prior to his skin disease he had always been strong.

It will be seen that although according to his statement the affection of the skin had begun as early as the age of seventeen, yet it had for many years given but little trouble, and had not been any bar to his marriage. That it had been severe at the age of twenty was, however, proved by his having come over to England for treatment. The enlargement of the femoral glands was unusually great, and the mass on the right side was so large that I advised their removal. They were, as usual, loose and had no tendency to inflame. They were excised by his own surgeon, or at any rate most of them were removed.

Mr. P—— at the present date (January, 1893) is still the subject of diffuse dermatitis, with much general thickening of skin and many little papular or even nodular indurations. He has several patches on his forearms, &c., which present

some tendency to fungate, but are for the present quite low and quiet. He is still in fair health, though he has lost flesh. There are large gland-masses in his groins.

I publish this fragment as a contribution to our knowledge of the early stages of the form of dermatitis which sometimes after many years furnishes examples of the fatal malady known as mycosis or granuloma fungoides. Most but not quite all of these are, as in this instance, exceedingly pruriginous and much aggravated by scratching. They are not to be distinguished by any definite feature from other forms of pruriginous eczema. Nor are they in their early stages incurable. The dermatitis is, however, very prone to develop, and in the end the patient's uncontrollable proclivity to scratching produces conditions which no treatment can overtake. By far the most definite condition which marks out a case of pruriginous dermatitis as likely to end in mycosis fungoides is the enlargement of the lymphatic glands. The kind of enlargement of them is peculiar. They are not inflamed, nor in the least painful, but remain soft and fleshy, quite distinct from each other and loose under the skin. The glands of the upper part of the thigh are those usually affected, and their position is also peculiar. They occur at some little distance below Poupart's ligament in the apex of Scarpa's triangle. They cause the patient no inconvenience excepting by their size, and they remain quiescent by slowly increasing for many years together. I never see a patient with enlarged glands in this position and of this character in association with eczema, without forming a very unfavourable opinion of his prospects. Almost all the cases which I have seen have been in men.

A CATECHISM OF SURGERY; WITH CASES FOR DIAGNOSIS.

No. CLI.—*Fracture of the Leg.*

A man had his leg broken by a kick from a horse. The bones are now strongly united, but with great ovoid swelling in the lower part of the leg. The leg is nearly two inches shorter than the other. The lower end of the upper portion of the fibula projects sharply under the skin about six inches above the tip of the inner malleolus.

QUESTIONS.

1. What was probably the character of the fracture?
2. Is it correct to speak of the ovoid swelling as being caused by provisional callus?
3. In what respect was the treatment of the case defective?
4. Is the displacement which has occurred that which is usual?

ANSWERS.

1. Both bones were broken: and from the nature of the violence, as well as the present condition of parts, it is extremely probable that there was comminution.

2. The swelling is due to the fact that the bones overlap each other, and that very probably some small comminuted fragments are placed across the line of the principal fracture. There is nothing of the nature of "provisional callus," which, as a matter of fact, occurs only in intraperiosteal fractures.

3. The defects in treatment were (1) that no real reduction was ever accomplished, and (2) that extension was not efficiently kept up.

4. There is no rule as to the displacement in cases of

fracture by direct violence, such as this was; the bones pass in such direction as the violence drives them.

No. CLII.—*The Circulation.*

1. What is meant by the expression "equalise the circulation"?

2. Mention some of the chief influences by which the due balance of the circulation may be disturbed.

3. What is meant by the expression "determination of blood to a part"?

4. Is it correct to speak of active and passive determination of blood?

5. What are the usual results of long continued, or often repeated, determination of blood?

6. What is the meaning of the expression "ubi iritatio ibi fluxus"?

7. Mention a good example of hypertrophy from determination of blood.

ANSWERS.

1. The expression is a very good one (although not much now in use) to denote the measures of treatment which favour the equal distribution of blood to all parts of the body.

2. Exercise stands in the very foremost place, and, on the contrary, all sedentary habits favour local congestions. A large number of drugs, especially those of the stimulant class with alcohol at their head, are, when judiciously used, very efficient in this direction. They favour the relaxation of arteries, and increase the vigour of the heart. Their effect is, however, less lasting than that of exercise, and, when it passes off, may be followed by a reverse condition. External heat is a powerful equaliser—such, for instance, as the hot bath. Heat applied locally, as, for instance, the pediluvium, is a very efficient means of counteracting a local congestion.

3. It means enlargement of the calibre of the arteries, and consequent increase of quantity of blood in the part supplied. It occurs in many conditions of functional activity, and in all congestions and inflammations.

4. The term "determination" should be restricted to

conditions in which some active influence is at work; other states may be spoken of as passive congestions.

5. Determination of blood, if slight in degree, will promote function and growth. If the latter passes beyond the limits of health, it would receive the name of "hypertrophy." If excessive, and especially if the blood-vessels be weak, determination may often result in rupture and hæmorrhage.

6. The expression denotes a general fact that the irritation of any part has the effect, through the nervous system, of producing local relaxation of the arterioles and increased supply of blood. The congestion of a flea-bite or a chilblain are fair examples.

7. The best example that can be given is elephantiasis in its various forms. Elephantoid hypertrophy is usually the result of repeated attacks of determination of blood from erysipelas. Other conditions, such as lymphatic obstruction, usually complicate the result; but undoubtedly the main cause of the overgrowth is repeated determinations of blood.

No. CLIII.—*Hemi-atrophy of Face and Facial Paralysis.*

I extract the following from a recent number of a medical journal:—"He also showed a baby with facial paralysis, the result of injury received at birth from the use of forceps, only noticeable when the child cries. This condition often leads to a permanent semi-atrophy of the face."

QUESTION.

Is the last part of this statement correct?

ANSWER.

No: the facial nerve (portio dura) is not a nerve having any influence over the nutrition of the parts supplied; its injury might leave the cheek baggy and loose, but would not in any way interfere with the growth. The cases of so-called hemi-atrophy of the face, which the writer of the paragraph probably had in his mind, are consequent upon disorder of the vaso-motor fibres, which travel chiefly with

the branches of the fifth. Hemi-atrophy is a consequence of morphœa (sclerodermia), but not of facial paralysis.

No. CLIV.—*The Abortive Treatment of Syphilis.*

QUESTIONS.

1. The term "abortive treatment of syphilis" is used by writers with reference to two different procedures. What are they?
2. What are the objections to the first of these?
3. Is the second of them practicable?
4. What are its details?
5. What directions are to be given to a patient as regards diet, &c., during a long course of mercury for this purpose?

ANSWERS.

1. By some the abortive treatment of syphilis is understood to mean the prevention of its development by the excision or destruction of its primary sore. By others the same term is used in reference to the prevention of the development of the disease by a course of mercury commenced as soon as the primary sore can be diagnosed.

2. It is scarcely ever efficient. By the time that an infecting chancre can be recognised as such, the virus has almost always passed into the lymphatics, and the excision of the original sore results only in disappointment.

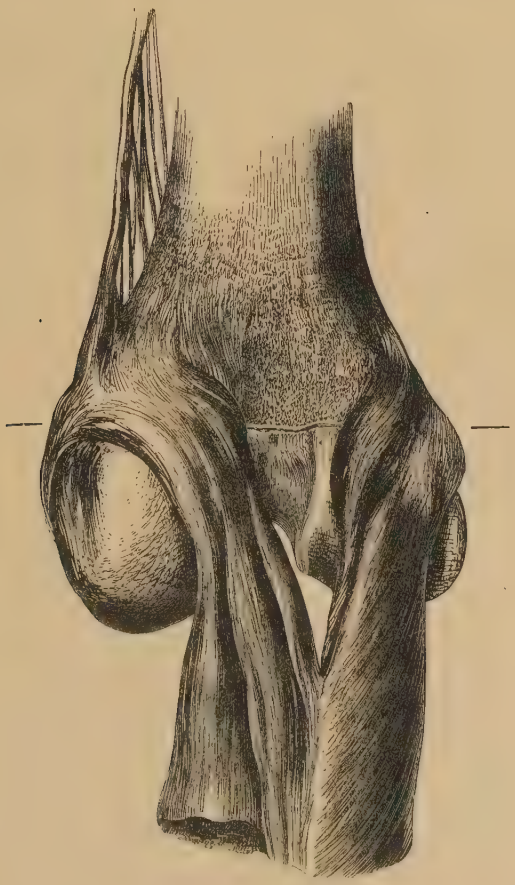
3. It is quite certain that the careful and efficient use of mercury, begun before any secondary symptoms have appeared, will in a large majority of cases entirely prevent their appearance, and thus abort the malady.

4. This abortive treatment by mercury may be carried out in many ways; but the most convenient is the use of grey powder in one-grain pills, in combination with opium. Of these the patient should take as many as he can bear without inconvenience from either ptyalism or diarrhœa. They may be taken three, four, five, or even six times in the twenty-four hours.

5. The chief difficulty in the treatment is to prevent diarrhœa, and with this object the most explicit directions

should be given, and insisted upon, as regards diet. The patient should take no green vegetables, soups, made dishes, coffee, or malt liquor. No stimulant is to be allowed, except a little spirit and water, brandy by preference.

No. CLV.—*Detachment of Lower Epiphysis of Femur.*



QUESTION.

In this woodcut we have represented the back of the femur, showing the attachment of the two heads of the gastrocnemius muscle and the line of the epiphysis. It will be seen that

the muscle is attached almost wholly above the epiphysal line. In a previous number of the ARCHIVES (see Catechism, page 287) it is stated that the lower epiphysis after detachment may be drawn backwards towards the popliteal space by this muscle. How can such a description be reconciled with the anatomical fact? Apparently it would be the lower end of the shaft upon which the muscle would act.

ANSWER.

It must never be forgotten that in all detachments of epiphyses the periosteum is extensively stripped, like a sleeve, from the lower end of the shaft: the latter is left quite bare. The periosteum sleeve, with which, of course, go all attached muscles, becomes, as it were, a part of the epiphysis, and thus permits the muscle to displace the latter.

No. CLVI.—*Congenital Tumour.*

This woodcut shows an infant affected by a large tumour of the sacral region.

QUESTIONS.

1. Are the appearances more suggestive of spina bifida, or or of what is known as the "coccygeal tumour"?

2. What is the nature of the "coccygeal tumour"?

3. May they be removed with safety?

ANSWERS.

1. From its dependent position and large size it is quite certain that the tumour is not a spina bifida. The cyst of a spina bifida is usually placed exactly in the middle line over the upper part of the sacrum, and seldom or never becomes so dependent as to be in the least visible from before. The position of this mass marks it clearly as an example of what is called a coccygeal tumour.

2. Coccygeal tumours may in very rare instances contain parts of an included fœtus. More usually they are examples of a peculiar cystic and solid growth, developed from embryonic tissue, between the coccyx and the rectum. They may possibly have their origin in the structure known as Luschka's gland. They sometimes envelop the coccyx and drag down and displace the rectum.*

3. These tumours, although large and very formidable, may often be removed with safety. They are loosely attached and do not pass upwards into the pelvis. Care must be taken not to injure the bowel. Such operations should not be undertaken during the first months of life.

No. CLVII.—*Symptoms in Joint Disease.*

QUESTIONS.

1. Mention one of the earliest symptoms of chronic rheumatic arthritis commencing in the shoulder-joint.

2. Mention one of the earliest symptoms of chronic rheumatic arthritis commencing in the hip-joint.

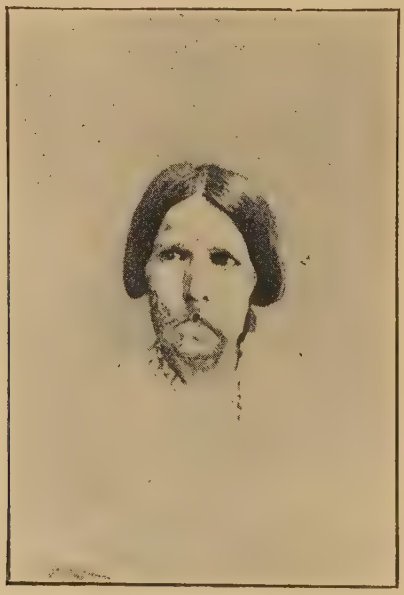
* For a description with good illustrations of appearances both during life and after dissection, see my "Illustrations of Clinical Surgery," vol. ii. p. 35. In Plate 49 of that volume the relations of the tumour to the bowel are well shown.

ANSWERS.

1. One of the earliest symptoms and one of the most constant, when disease is commencing in the shoulder, is inability to put the hand behind the back. A man complains that he cannot button his braces, a woman that she cannot lace her stays.

2. One of the first symptoms in reference to the hip-joint is difficulty in getting at the foot. The patient finds himself obliged to resort to artifice in order to put on his boots. Very often this has come on so gradually that it has scarcely been noticed, but, if the surgeon inquires about it, will usually be at once admitted.

No. CLVIII.—*Cicatricial Contraction of Mouth.*



QUESTIONS.

1. What is the condition shown in the above illustration?

2. Of what disease is it probably the result, and what would be the appropriate treatment?

ANSWERS.

1. The woman's mouth is so far closed by cicatrix after

destruction of the lips that it would barely admit a large pencil. The scar may have been consequent on several different forms of destructive ulceration, sloughing after a burn, cancrum oris, &c. It is, however, extremely improbable that from either of the two causes suggested such peculiar puckering up of the mouth would result. Sloughing from either of these causes would probably involve the whole thickness of the lip and cheek, and leave a large gap instead of a contracted orifice. The peculiar contraction present suggests that not the whole thickness, but only the skin surface of the lips, &c., was destroyed.

2. The only disease likely to have done this is lupus (it was from this affection that the woman had suffered). It will be seen that a superficial scar extends over the chin and on to both cheeks. The treatment most likely to succeed would be by moderate incisions on both sides, and then, if possible, bringing the mucous membrane from within to cover the cut edges.

No. CLIX.—*The Mammilated Pharynx.*

QUESTIONS.

1. Our forefathers used to speak of the "mammilated pharynx;" what are the modern terms in use for the condition so named?

2. Describe the physiognomy of a patient suffering from these growths.

3. Is the condition an important one, and what symptoms may it produce?

4. Is it to be regarded as an indication of diathesis, or as a result of disease?

5. What are the measures of treatment?

ANSWERS.

1. The term "mammilated pharynx" was formerly applied to the little reddish granulation-like masses so often seen scattered over the upper part of the pharynx in young persons. They are now known as adenoid growths, and usually imply the presence of yet larger ones concealed above

the palate. To the latter the terms "post-nasal growths" or "adenoid vegetations" are often given.

2. The growths, if considerable, cause obstruction in the naso-pharynx, and this causes the patient to keep his mouth open in order to breathe, and a more or less dull and stupid expression is assumed.

3. It is believed that not only does the patient look dull, but that he becomes really so. This may be partly due to the deafness which attends the malady, and partly to the fact that, never being in perfect comfort, it is difficult for him to give efficient attention to anything; they may also, by interference with respiration, cause definite injury to the general health.

4. In the first instance they are undoubtedly to be regarded as indications of diathesis or of family tendency, but they may subsequently, in such connections as chronic catarrh, &c., become the seats of disease.

5. Their removal by operation is by far the simplest measure, and should never be neglected. It is easily effected by specially contrived forceps, or even by the surgeon's finger-nail.

The complete clearing of the patient's throat and nasal pharynx from enlarged tonsils and these adenoid growths may be the means of effecting a most satisfactory change in the child's health, comfort, physiognomy, and even character.

No. CLX.—*Modes of introduction of Syphilis.*

QUESTIONS.

1. Mention the principal means by which syphilis may be initiated.

2. In addition to the four which have been named, is it probable that there are any others; more especially, what is your theory as regards the not very infrequent cases in which no chancre is ever recognised?

ANSWERS.

1. Syphilis may be produced—

(1) By contagion from a chancre (whether with abrasion or without). A chancre results.

(2) By contagion from a secondary sore secreting pus (with or without abrasion). A chancre results.

(3) By contagion from the blood of an infected person. A chancre results.

(4) By the placental contact of the blood of a mother with that of her fœtus. No chancre occurs.

2. It must be admitted to be possible that the introduction of the blood of a syphilitic patient directly into the blood vessels of another might produce syphilis without any antecedent chancre. In practice, however, such an occurrence is barely possible. As regards the occurrence of syphilis without chancre, it is to be admitted that primary sores may vary very greatly in their appearances, and may sometimes be exceedingly inconspicuous. These differences probably depend in part upon the idiosyncrasies of the individual, in part upon the mode of contagion, and in part upon the structure of the tissue inoculated. It must be freely admitted that it is possible for the virus of syphilis to be absorbed without the occurrence of any ostensible chancre.

No. CLXI.—*On Circumcision.*

QUESTIONS.

1. Under what circumstances is the operation of circumcision in infancy desirable?

2. How should it be performed; ought stitches to be used?

3. What special risks attend it?

ANSWERS.

1. It is imperatively required whenever the prepuce is unusually long and contracted at its orifice. The surgeon should, however, avail himself of every possible opportunity of inducing parents to have their male children circumcised. The operation confers great advantages in several different directions. If properly done, it has no drawbacks whatever.

2. For the performance of circumcision, the surgeon should be provided with two pairs of straight scissors—one large, the other small. Drawing the prepuce a little forward, he should include all that is in front of the glans between the

handles of his smaller scissors, and nipping it tightly, should then with the larger ones cut all the projecting part away. This will remove a broad ring of skin and leave the glans covered only by mucous membrane. Next, with his smaller scissors, he should slit up the mucous membrane and cut it cleanly away level with the corona. Not more mucous membrane than a strip of about one-eighth of an inch in width should be left. If any adhesions are present they should be carefully broken down. What remains of the frœnum may now be tied; no other vessels will need attention. Stitches are quite unnecessary, and generally inconvenient and injurious.

3. By far the most important risk is that of hæmorrhage, and very careful attention should be given to the ligature of the frœnum. Many children have died after the operation in consequence of carelessness in this matter. The only other risks are poisoning of the wound by unclean instruments, and the introduction of syphilis by the dressings, &c.*

No. CLXII.—*Variolation and Vaccination.*

QUESTIONS.

1. What is the difference between vaccination and variolation?

2. Is it probable that variola can be transmuted into vaccina?

3. What is meant by the term "vaccinia eruption"?

4. What are the chief differences between the pock produced by variolation and that of vaccination?

ANSWERS.

1. By vaccination is meant the introduction of a virus derived, directly or indirectly, from pocks on the udder of

* In my work on Syphilis I have recorded a series of cases, in which a Jewish circumcisor communicated syphilis by unclean lint. I have recently been consulted in a case in which, in all probability, an operating surgeon did the same by his instruments.

the cow.* Variolation is inoculation with small-pox matter derived from the human subject.

2. It is probable that all vaccine lymph is derived from human variola transmuted by passage through the system of a cow.

3. In not a few cases after successful vaccination an eruption appears on the child's body from the eighth to the fourteenth day. This eruption may vary a good deal in character. It is usually symmetrical and vesicular. In rare cases it may closely resemble variola. To this eruption, whatever appearance it may assume, the term "vaccina rash" is applicable. It is the exanthem of the vaccination fever, and the wonder is that it should not be present in all cases.

4. The two pocks very closely resemble each other, and as regards dates, they run an almost parallel course. Their chief difference is that, while those of vaccination remain single, however much the inflammation of the arm may be, those of variolation are constantly attended by the formation of little satellites around their margins, which often, at a later stage, coalesce with the parent pock.

No. CLXIII.—*Elephantiasis and Hypertrophy.*

QUESTIONS.

1. What is the condition of the arteries in a limb affected by elephantiasis?

2. Of what inflammatory affection is elephantoid hypertrophy the ordinary result?

3. Is there any real difference between elephantoid hypertrophy and true elephantiasis?

4. What parts are most usually the seats of elephantiasis?

5. Is there any real difference between hypertrophy of scars and keloid?

* The term "vaccination" has been much widened by modern experimenters, as it is now used to include the purposeful inoculation with any virus which is supposed to have been attenuated.

ANSWERS.

1. The arteries are always dilated, and their dilatation attended by thinning of the coats: this is especially definite in the case of the femoral arteries, and constitutes an important source of danger.

2. Most cases of elephantiasis begin in erysipelas: it is often a consequence of slight wounds or abrasions.

3. There is no real difference between elephantoid hypertropy and "true elephantiasis." What is called elephantoid hypertrophy is usually only a slight form or an early stage of what, when well-advanced, every one would call elephantiasis.

4. Elephantiasis is usually developed in parts which are more or less independent, and which, as a consequence, do not readily relieve themselves from œdema. The legs and the genitals in both sexes are the regions which are its most frequent seats. It is very rarely seen in the upper extremities, but the lower eyelids and the lips may occasionally become its seats.

5. As there is only a difference in degree, or perhaps in the stage of development, between elephantoid hypertrophy and elephantiasis, so also hypertrophy of scars is only a stage or degree of keloid. We find keloid to be fibroid hypertrophy of scar tissue; it may vary very much in the characters it attains to in different cases.

No. CLXIV.—*The Cause of Conical Stumps.*

Richter records of a case in which he had amputated through the thigh: "I saw the patient eighteen months after, and, to my great astonishment, found that all the muscles round the bone had retracted in such a manner that the bone projected a whole handbreadth, covered only with the skin."

QUESTION.

What was probably the age of Richter's patient?

ANSWER.

The cause of conical stump is almost always the growth of the bone subsequent to the amputation. It grows, of course,

from the epiphysis above. We may therefore always infer, respecting a case in which a stump has become conical, that the patient was young. (Richter's patient was a lad of fourteen.)

No. CLXV.—*Missing Words.*

To test his knowledge of the History of Medicine, the reader is requested to supply the omitted names in the following quotation :—

"The first Physicians had but a very faint notion of the Brain presiding over the Animal system by the Mediation of the Spinal Marrow and Nerves produced from it, and distributed to the rest of the Body. And we must acknowledge this was not sufficiently understood before and , the greatest Anatomists of Antiquity, who explained this Scheme and left the World no Room to doubt of this elegant Piece of Mechanism of the animal Body. Physicians began to dissect with more than ordinary care both living and dead animals; and they soon found that by cutting, tying, or compressing any Nerve, or any other way intercepting its Communication with the Brain, the Parts to which it belonged were immediately deprived of all Sense and Motion.

"It was easy to confirm this Doctrine by experiments on any of the ordinary Nerves. But one of the prettiest Instances of it, was the making Ligatures upon the Vessels at the Side of the Wind-pipe, and immediately striking the Animal dumb, however noisy it was before. The first Makers of this experiment thought the Animal turned comatous, or fell asleep ; and ascribing this Effect to the intercepting any Passage of vital Blood from the Heart to the Brain, by the Way of the Arteries ; they gave these Blood Vessels the Name of *Carotids*, καροτιδῶν. But in the days of , this sudden Silence of the Animal was found to proceed from the tying of the adjacent Nerves, and , who seems to have laboured this Affair more than any of his Predecessors, evidently proved, that tying the Arteries solely produced little change on the Animal. In this Case (laying aside the

Captions, Cavils, and Oppositions of , , , and others of the Moderns, who disputed against the experiment, which, however easy, they would not take the trouble to repeat), we must conceive the Brain to have been furnished by the vertebral Arteries. And so he found all that the Animal suffered in the experiment of tying the whole Vessels at the side of the Trachea, to be a sudden Obmutesence, which entirely proceeded from the intercepting the nervous Influence on the Muscles of the *Larynx*. For he discovered that these Nerves were derived from the Par vagum, and that they, making a Turn under the right subclavian Artery, and descending *Aorta*, climbed up along each Side of the Wind-pipe, to furnish these Muscles.

The Oddness and Novelty of all this Doctrine was in those Days surprising. The *Virtuosi* at *Rome* knew nothing of it; yea, of , the and Preceptor of , was resolved to deny and oppose it at any Rate. He would rather resist the Evidence of Sense than yield anything that might contribute to the rising glory of , his Rival. But our Anatomist, in the midst of a learned and judicious Assembly, consisting of Adversaries as well as Friends, by ocular Demonstration, gave them at once a convincing proof of the Truth of his Doctrine, and of his own extraordinary Skill in Dissections. Yea, this was confirmed by some casual Observations made on some of our own Species. An unlucky scrophulous Boy falling into the Hands of an ignorant Surgeon, lost the half of his Voice by having one of the Recurrent Nerves cut along with the Tumour. However, he escaped better than another Boy, who in the like case was indeed cured of the *Strumæ*, but, having both the Recurrents extirpated, was left quite dumb."

PLATE LXXII.

AN EXCEPTIONAL FORM OF LUPUS.

This portrait represents the face of a woman about fifty years of age, in whom the disease had existed only six months. The disease was, I believe, essentially lupus vulgaris, but presented exceptional features and had spread with immense rapidity. There was no reason whatever to suspect syphilis. The disease had commenced in the middle of the flush-patch of the cheek, and with so much inflammatory induration that it was at first suspected to be carbuncular. After a little time the swelling subsided, and the disease lapsed into a chronic form and spread by contagion-of-continuity at its edges. At the same time a satellite sore was developed on the forehead. There was no implication of the lymphatic glands, and the mode of spreading was quite characteristic of lupus. There was never at any time anything which could be recognised as "apple-jelly growth." Great benefit was obtained by free cauterisation with the acid nitrate of mercury.

Wm. Newman, chrom

PLATE LXXIII.

THE SEBACEOUS FORM OF LUPUS ERYTHEMATOSUS.

(Copied from Hebra's Atlas.)

Lupus erythematosus presents itself in different forms. In some cases the parts implicated present erythematous congestion almost solely. (A good illustration of this is given in the next Plate). In others there is an extensive implication of the sebaceous glandular system. Comedones are frequently found, and the patches are roughened over, like a piece of orange-peel, by the open orifices of glands and little plugs of dried sebum. The portrait which is given in this Plate is one which I have copied from Hebra's Atlas, because I do not myself possess one which so well illustrates the combination of conditions characteristic of the sebaceous and erythematous form. In many cases of lupus sebaceus the disease remains long limited to the nose, and but rarely assumes the bat's-wing form, or becomes accurately symmetrical. Thus it would appear to be a sort of connecting link between lupus vulgaris and lupus erythematosus. In this portrait, however, we see the disease very accurately symmetrical, whilst the implication of sebaceous glands is extensive and conspicuous. The margins of the patches consist of confluent groups of enlarged glands and are covered by dry seborrhaic secretion.

PLATE LXXIV.

THE ERYTHEMATOUS FORM OF LUPUS ERYTHEMATOSUS.

This Plate is the portrait of a boy who was the subject of the most superficial and purely erythematous form of lupus erythematosus. It will be seen that almost the whole of his nose is involved in erythema, and that bat's-wing patches extend symmetrically over both cheeks. There was little or no thickening, and only the slightest possible desquamation; and there is no evidence of special involvement of sebaceous glands. In this latter respect the case may be contrasted with the preceding Plate. It will be seen that on the boy's upper lip, close to the pro-labium, there is a half disc of erythema which shows more thickening than other parts. The development of satellite discs of this kind is, as all know, a very characteristic feature of the disease.

PLATE LXXV.

LUPUS VULGARIS IN MULTIPLE DEVELOPMENT.

This portrait shows a condition of most extensive multiplicity of patches of common lupus. The conditions of the several patches were quite characteristic, the "apple-jelly" growth being abundant and well characterised. The patches were spreading at their edges, and some of them already showed cicatrices in their centres. The patient had almost innumerable patches on the face, shoulders, and limbs. They were so abundant and so nearly symmetrical that I was inclined at the time to consider the case an example of lupus-psoriasis. The symmetry was, however, by no means exact or complete, and I am quite prepared to admit that the case does not differ in any feature from common lupus, excepting in the exceptional number of patches. As is usual, when lupus vulgaris occurs in multiple patches, the multiplicity was produced in the first stage of the disease. The patient was a girl about twelve years old, who was under my care at the London Hospital many years ago, and who was the subject of angular curvature of the spine with abscess.

The multiplicity of patches of common lupus, just as shown in this portrait, is well illustrated in two models in the Museum of the St. Louis Hospital at Paris. In both, as in the above, the patient was a child. The reader may also refer with interest to Plates LXXVI. and LXXVII., in my last 'Archives.'

West, Newman, chromo

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